S. HRG. 103–175

A HELPING HAND: PROMISING APPROACHES FOR SUPPORTING FAMILIES

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

EXAMINING APPROACHES FOR SUPPORTING FAMILIES IN AN EFFORT TO ELIMINATE ABUSE AND NEGLECT AND TO ASSIST FAMILIES THAT HAVE, OR MAY DEVELOP, HEALTH AND RELATED PROBLEMS FOCUSING ON HOME VISITING, FAMILY-CENTERED SUBSTANCE ABUSE TREATMENT, AND FAMILY RESOURCE AND SUPPORT PROGRAMS

APRIL 28, 1993

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE
69–366cc WASHINGTON : 1993

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-041404-0

S. HRG. 103–175

A HELPING HAND: PROMISING APPROACHES FOR SUPPORTING FAMILIES

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

EXAMINING APPROACHES FOR SUPPORTING FAMILIES IN AN EFFORT TO ELIMINATE ABUSE AND NEGLECT AND TO ASSIST FAMILIES THAT HAVE, OR MAY DEVELOP, HEALTH AND RELATED PROBLEMS FOCUSING ON HOME VISITING, FAMILY-CENTERED SUBSTANCE ABUSE TREATMENT, AND FAMILY RESOURCE AND SUPPORT PROGRAMS

APRIL 28, 1993

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

69–366cc WASHINGTON : 1993

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-041404-0

COMMITTEE ON LABOR AND HUMAN RESOURCES

EDWARD M. KENNEDY, Massachusetts, *Chairman*

CLAIBORNE PELL, Rhode Island
HOWARD M. METZENBAUM, Ohio
CHRISTOPHER J. DODD, Connecticut
PAUL SIMON, Illinois
TOM HARKIN, Iowa
BARBARA A. MIKULSKI, Maryland
JEFF BINGAMAN, New Mexico
PAUL D. WELLSTONE, Minnesota
HARRIS WOFFORD, Pennsylvania

NANCY LANDON KASSEBAUM, Kansas
JAMES M. JEFFORDS, Vermont
DAN COATS, Indiana
JUDD GREGG, New Hampshire
STROM THURMOND, South Carolina
ORRIN G. HATCH, Utah
DAVE DURENBERGER, Minnesota

NICK LITTLEFIELD, *Staff Director and Chief Counsel*
SUSAN K. HATTAN, *Minority Staff Director*

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

CHRISTOPHER J. DODD, Connecticut, *Chairman*

CLAIBORNE PELL, Rhode Island
BARBARA A. MIKULSKI, Maryland
JEFF BINGAMAN, New Mexico
EDWARD M. KENNEDY, Massachusetts
PAUL D. WELLSTONE, Minnesota
HARRIS WOFFORD, Pennsylvania

DAN COATS, Indiana
NANCY LANDON KASSEBAUM, Kansas
JAMES M. JEFFORDS, Vermont
JUDD GREGG, New Hampshire
STROM THURMOND, South Carolina
DAVE DURENBERGER, Minnesota

RICHARD J. TARPLIN, *Staff Director*
STEPHANIE JOHNSON MONROE, *Counsel*

CONTENTS

STATEMENTS

APRIL 28, 1993

ADDITIONAL MATERIAL

A HELPING HAND: PROMISING APPROACHES FOR SUPPORTING FAMILIES

WEDNESDAY, APRIL 28, 1993

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM,
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:03 a.m., in room SD–430, Dirksen Senate Office Building, Senator Christopher J. Dodd (chairman of the subcommittee) presiding.

Present: Senators Dodd, Wellstone, Kassebaum, and Coats.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The subcommittee will come to order.

Let me welcome everyone here this morning. I'm going to ask Governor Chiles and Lynda Johnson Robb, who is a member of the commission to Prevent Infant Mortality, as well as Sarah Whye, from Washington, DC., to join us at the witness table. And I'm going to ask Wanda Cave to come up and sit at the table as well, if she would.

With the permission of our witnesses, I am going to make a few brief opening comments, and then I'll turn directly to our first panel. I want to welcome them. The other witnesses will appreciate the fact that welcoming Governor Chiles is a special pleasure. He is a former colleague, and I owe him many things, not the least of which is that I am a member of the Budget Committee, which I have tried to get off now for several years after he convinced me to go on it, and I can't get off—it's the only committee you can't get off of once you get on; you are on for life, unless you run for governor someplace, I guess. At any rate, it's a pleasure to have you back in familiar surroundings.

Welcome to everyone here this morning to the Subcommittee on Children, Family, Drugs, and Alcoholism's hearing on "A Helping Hand: Promising Approaches for Supporting Families."

In our Nation today, many families face almost unbearable economic and social stresses. The struggle to make ends meet, early childbearing, the daunting responsibility of a new baby, and substance abuse—all can reduce a parent's ability to cope.

Sadly, the barometer of these difficulties often is child abuse and neglect. At the beginning of this month, which is National Child Abuse Prevention Month, the National Committee for the Prevention of Child Abuse offered an unsettling gauge of how our children

bear the brunt of social ills: Almost 3 million children were reported as having been abused or neglected in 1992, up 8 percent from 1991. Children died because of maltreatment at a shocking rate of more than three a day in this country.

Other indicators are equally troubling. In 1990, the United States ranked behind 20 other industrialized nations in infant mortality. Over the last decade, the proportion of mothers receiving late or no prenatal care worsened for all but mothers over age 35. Local studies in my own State of Connecticut consistently show rates of prenatal drug exposure of one in 10 births or higher. Let me repeat that: One in 10 or higher where there is drug abuse. Clearly, many children begin life already at risk, which is obvious to many of you in our audience.

Today, however, we want to end our observance of Child Abuse Prevention Month with a message of hope. We know how to reach out to families to help them grow stronger. We know how to help parents raise healthier children. We know of promising approaches that can offer families a helping hand before they reach a crisis.

Today we will focus on three such approaches that have been authorized in legislation over the past few years. They are by no means the only models for family support. Yet I believe they should be the foundation of a system that builds on a family's strengths, rather than reacting only when its shortcomings become tragically apparent.

These approaches—home visiting, family-oriented substance abuse treatment, and family resource and support programs—have several traits in common. All recognize that being a parent is a tough job, and few people are born knowing how to do it. All see a family's potential and work to overcome problems that may seem insurmountable to realize it. All offer positive support when it can help, not a knock on the door when it is far too late.

Home visiting is a simple yet powerful concept: Workers, who often are drawn from the communities they serve, reaching out to vulnerable families in their own neighborhoods, usually when a child is born, and empowering them to become stronger and more nurturing. Home visitors offer help ranging from advice on coping with toddler tantrums, to linking families with health services, to simply just being there to talk. And that is not an insignificant contribution.

Research has shown home visiting effective in improving child health and reducing abuse and neglect. The National Commission to Prevent Infant Mortality, led by Governor Lawton Chiles, and Lynda Robb as a member, and Mrs. Whye is a person who can talk very directly on how this can work, have launched an effort to spearhead it in more communities across the country. Last year, we succeeded in enacting a Federal home visiting program, but have yet to secure the funding necessary that this approach needs in order to grow.

One of the most difficult problems a family can face is substance abuse. Treatment programs often address addiction in isolation, ignoring the other issues that women with children in particular must face if they are to hold their lives and their families together. Physical abuse in their own backgrounds, lack of parenting tools, and the fate of their children while they seek treatment all must

be resolved. In addition, the children themselves need comprehensive assessments and care. This was the rationale behind the Children of Substance Abusers grants enacted last year—a family support program for children and families affected by substance abuse.

The third approach is the Family Resource and Support Program, which is used in my own State of Connecticut, as well as in Maryland, as we will hear today. In 1990, we included funding for this approach in the Young Americans Act; the first grants are to be awarded later this year. These neighborhood-based centers seek to build on a family's strengths as they boost parenting skills, link families to community services, and build support networks for parents. Most important, they have the ability to address family needs comprehensively, helping weave a seamless garment of services. As such, they can form the basis for reform in our system for serving families.

The Clinton administration has emphasized the need to strengthen families and to set aside money in the budget for family support and parenting. I welcome that emphasis; it is long overdue. As they move forward with their proposal, I encourage the administration to look at these promising programs that we will talk about today that are already written into law.

Above all, our national policy must recognize that the family is the basic cellular structure of our society, and of any society, for that manner. When the family does not function, society is inevitably diminished. As the writer Maya Angelou—herself no stranger to a system that dwells on a family's deficits—puts it: "At our best level of existence, we are parts of a family, and at our highest level of achievement, we work to keep the family alive."

Surely, families and children merit a helping hand, a lifeline of hope, before they are swept into a maelstrom of despair.

At this point I would like to insert a statement from Senator Mikulski.

PREPARED STATEMENT OF SENATOR MIKULSKI

Mr. Chairman, I would like to welcome the witnesses for this morning's hearing on promising approaches for supporting families. Governor Chiles, I know of your important work on children's issues. I look forward to your insights, along with those of Mrs. Robb, on the Resource Mothers Development Project and home visiting programs. It is also a great pleasure to welcome Joanne Woodward, who has played an important role in raising awareness about substance abuse in families.

I would especially like to recognize and welcome Margaret Williams from Friends of the Family, who is here to talk about Maryland's Family Support Centers. It is a great pleasure to have Ms. Williams here today because Friends of the Family is providing an important network of support to young families throughout Maryland. Also, it is a pleasure to welcome Shurnice Mackey, a young mother from Baltimore. She is here to tell us how Family Support Centers have helped her.

Maryland, with the help of Friends of the Family, has been very progressive in recognizing the importance of Family Support Programs. When we provide families with basic support services, families can better understand how to provide for themselves and their

young children. Helping families help themselves keeps families together and strong. And strong families create the caring environment children need to grow and learn.

Maryland has 15 Family Support Centers, which provide a continuum of care for families. These centers offer parenting education, child care services while parents are on-site, health education and referral for health care services and education and employment services. For the young mother in Baltimore this means she and her child can visit a community center or a school right in her neighborhood. While her child is in the on-site child care facility, the young mother can learn about parenting skills, immunizations for her child or employment skills.

I believe that Maryland's Family Support Centers are a good example of how helping people help themselves can make real change in people's day-to-day lives. Family support centers in Maryland have helped teen parents work toward their high-school diplomas or equivalency degrees. More families that visit Family Support Centers have children that are up-to-date on immunizations.

Today's hearing is looking at promising approaches for supporting families and that is an important step to recognizing that we need to help people help themselves. By supporting families early on, we help build strong families and help create an environment for children to grow and develop.

Senator DODD. So we thank our witnesses and my colleagues, Senator Coats and Senator Kassebaum, for being here this morning. Before turning to our first panel, I will ask my co-chair here, Senator Coats, for any opening statement he may have.

OPENING STATEMENT OF SENATOR COATS

Senator COATS. Briefly, Mr. Chairman, thank you, and thanks to our witnesses. I am particularly pleased to see a friend and former colleague, Governor Chiles, here this morning; and Mrs. Robb, we appreciate your presence, also, as well as the other witnesses.

Mr. Chairman, the family in America today is faced with challenges that can cripple it: drug abuse, child abuse, family violence, gang warfare, murder, suicide, financial pressure, job loss, teenage pregnancy, AIDS—on and on it goes, the litany of concerns and problems and challenges that our families of today have to face.

At some level, we recognize these problems are beyond the reach of government, and they have deeper roots in the future of values and of citizenship. But even in this chaos, volunteers and local programs are a source of order and a source of hope; they touch people in places inaccessible to the blunt instruments of Federal policy and Federal bureaucracy.

The family support system in America is an example. It has provided a web of programs and support mechanisms designed to help families at a moment of need—not necessarily with a handout, but with emotional and community support. These programs treat families as something worth preserving. Because of their success, they have become a mainstay in many urban and rural communities across the country. These programs are promising and unique because in most cases, they involve a public-private partnership in funding and administration. Home visitation, family-centered substance abuse programs, and family support centers all offer fami-

lies an opportunity to get the help they need before things get out of hand. Too often, services deal with the results of failure; these programs that we are talking about today encourage success.

I am particularly pleased that we will be hearing today about family support centers. I have been interested in this approach for a number of years, sponsoring legislation in both the House and the Senate to provide Federal incentive grants to States and local communities interested in establishing these centers. In 1990, I had the pleasure of working with you, Mr. Chairman, to see that language authorizing these programs was included in the human services reauthorization bill.

Family support centers, in addition to providing one-stop shopping for many social services, are a place where a young mother can go for support, encouragement, or help with her responsibilities at home. She can talk with other mothers while her children play and get professional advice about her children's special health needs. It is a place for fathers as well, and several support centers have started programs targeting young fathers, an exciting innovation.

Family support programs cannot solve all the family's problems, and they cannot rescue families in need of significant repair. Some families need more intensive help than family support programs can offer, and some children may need to receive help away from their parents. But family support centers can and do significantly reduce the number of children and families needing intensive intervention by recognizing that family problems often start small and intensify over time.

By focusing on prevention and family preservation, family support programs can fill a void left by an overburdened and bureaucratized social service system that is often rigidly compartmentalized and complex.

I look forward to hearing from our witnesses and learning more about these very important programs.

Senator DODD. Thank you very much, Senator Coats.

Senator Kassebaum.

OPENING STATEMENT OF SENATOR KASSEBAUM

Senator KASSEBAUM. Mr. Chairman, I am just hear to lend support to this important hearing. I am pleased that you, as chairman of this subcommittee, and Senator Coats as ranking member have called it. I would add that Senator Chiles, of course, as Senator, gave many countless hours of dedication to these same issues as Senator and is continuing that dedication as Governor. I'm looking forward to the panels and the witnesses before us and welcome them.

Senator DODD. Thank you very much.

Senator DODD. I have already sort of introduced our former colleague, and let me just underscore what Senator Kassebaum has said. This is not a new issue to Governor Chiles. As a colleague in the Senate, he cared deeply about these questions as a Senator from the State of Florida. It was no surprise at all that you would be chairing the commission and have done a tremendous job with it. We know that all the members of the commission have worked very, very hard—and I realize that many of them have probably

had different demands on you as Governor in trying to hold the commission together, and I want you to know I am sensitive to that, Governor, and appreciate immensely the work you have been able to do.

STATEMENTS OF HON. LAWTON CHILES, GOVERNOR OF THE STATE OF FLORIDA; LYNDA JOHNSON ROBB, MEMBER, COMMISSION TO PREVENT INFANT MORTALITY, McLEAN, VA; SARAH WHYE, OUTREACH WORKER, WASHINGTON, DC., AND WANDA AND MICHELLE CAVE, WASHINGTON, DC.

Governor CHILES. Thank you, Mr. Chairman, and to your colleagues on the committee. I am delighted to have this opportunity to be here and know that each of you have shown throughout your careers a very strong interest in children, in needs of families, and in trying to find cost-effective ways that we can deal with some of the problems that we have.

I am delighted to be here with Lynda Johnson Robb, who has served as a valuable member of the commission since our inception and prior to that as First Lady of Virginia, was very involved in the very programs that we are talking about today, Resource Mothers; and certainly, Sarah Whye has her experience in the District. But perhaps greater than that will be the testimony that Wanda Cave and Michelle, who are here with us, can give because they can really tell and show what this program is about.

We think that you are to be commended for looking at promising approaches for supporting families; that, I think, is what we really have to do. We have to try to find ways that we can have the public-private partnership. We have to find ways that we can encourage volunteering and that we can maximize, certainly, the resources. All of that means that we have to go back and try to spend our first dollar effectively, and that is for prevention, for primary care, for trying to take care of problems before they get to be so strong.

You have cited the figures that are a tragedy for this Nation to rank where it does in regard to infant mortality, in regard to low birth weight babies. With our resources, there is no reason—and I used to ask myself when I first looked at this figures, and I think many Americans do not understand those figures at all, do not comprehend that we rank so low, or what that means to the country—but I can remember well when I would first see those figures, I would ask is there something wrong with our medicine. Not at all. Our medicine is the best in the world. In fact, all of our reductions have been based upon the gains in our medicine, the technology, and we have relied on that; but what we have not done that less developed countries in many instances have done is take care of mothers during their pregnancy, see that they are cared for, that they eat right, that they understand what is important, how they should treat their bodies, and screen those women early on to find that percentage that are going to have problems, and in so many instances we can deal with them very effectively if we have screened them to start with.

So we have spent all of our dollars on the back end of the problem in the neonatal facilities—they are wonderful, and we save an awful lot of babies. The ones that we save, we then get to take care

of for the rest of their lives, and many times, they have great problems because of difficulties, again, that could have been so easily prevented.

Today we come to you just to say, from the National Commission, working with Nestle, that we have put together some materials in regard to the program of Resource Mothers. This is—and you have talked about it—a home visiting program which is cost-effective as well as human-effective; it is user-friendly. We are talking about going into neighborhoods, getting women who have successful raised their children, giving them some training and sending them back into the neighborhoods to be friend and counselor, to help pregnant women cut through the red tape of trying to get the forms filled out, in many instances to admonish them if they aren't treating their bodies right—and they will take that from people that they know love them, respect them, and care for them in their neighborhood. It is interesting that there is enough experience on this to know that these programs are very effective. They reduced the repeat pregnancies from 50 percent; low birth weight babies will go to almost nothing for women who are covered; the infant mortality rate is halved at least. And with that, the National Commission, in trying to make these more accessible, has put together some material with Nestles, which we can provide to any group that would like to start such a program, and for $65, all of the information is here. This can be pulled off the shelf, and it comes in several models, depending on whether you want to have an all-volunteer program, or whether you have some resources to put into it. It is based on experience that we have catalogued across the country. So it is one of the things that we feel we can do in promoting this partnership that has to be from the public to the private sector in trying to do that.

We certainly encourage your committee and the Congress to try to make sure there are some assets, that programs do allow this to happen. Anything that we are doing on the prevention side is going to be the most effective health dollars that we can spend.

As we go to universal access—and in Florida, we passed a bill to try to get Florida on the forefront of that—we know that the dollars we spend on the front end will give us a payoff of 5 to 15 over dollars that we are having to spend on the back end.

So we are here today to say that we congratulate you on what you are doing; we hope that we can publicize what are attempting to do, that there will be some programs that will be available where grants will be sought, or people will be trying to do that, and also to use the ability of this forum to highlight what Wanda can tell us about a very successful program.

I am delighted to be here.

Senator DODD. Thank you immensely, Governor, for that testimony.

[The prepared statement of Governor Chiles follows:]

PREPARED STATEMENT OF GOVERNOR LAWTON CHILES

Good morning, Mr. Chairman and members of the subcommittee. I want to thank you for the opportunity to participate in this morning's hearing on "Promising Approaches for Supporting Families." I commend you for electing to focus not only on the serious problems facing the nation's children and families, but for concentrating on solutions. All-too-often in discussions about the poor state of families in the Unit-

ed States, we forget the most important point—that we know what to do to improve their health and well-being. What we lack are the commitment and leadership to put our knowledge into action. By holding this hearing, you are sending a strong signal that taking action on behalf of families in need can be done and must become a priority for us all.

I am delighted to be here today with a fellow member of the National Commission to Prevent Infant Mortality, Lynda Johnson Robb, who has led the way in Virginia and across the Nation in support of Resource Mothers programs. We are also joined by Mrs. Sarah Whye, who works for a local home visiting program here in Washington, DC.

As you know, Mr. Chairman, we all just came from a press conference to launch a new national initiative called the Resource Mothers Development Project. This project was developed by the National Commission to Prevent Infant Mortality and is an example of the very kind of program that this hearing is all about. But before I describe the project, I'd like to set the stage on which Resource Mothers do their job.

As you well know, our nation's families are in trouble. In 1990, the United States' infant mortality rate of 9.2 lagged behind the rates of 19 other industrialized nations. The United States has a worse record than over 2 dozen other nations in the number of babies born low birthweight—that is, those born weighing less than 5½ pounds. This is particularly significant because the 7 percent of babies born low birthweight account for 60 percent of all babies who die before their first birthday. And those who survive are 2 to 3 times more likely to suffer from short and long term disabilities. One reason for these troubling trends is that there has been virtually no improvement in the percentage of women beginning prenatal care in the first trimester—only about 75 percent do so. Meanwhile, a quarter of infants are born into families with incomes below with federal poverty level, which puts them at risk for a host of health and social problems.

Lack of access to basic health and social services is a key contributor to the problems facing children and families. In my own State of Florida, we recently passed the Florida Health Plan which will extend health care coverage to all Floridians. But I know and you know, Mr. Chairman, that a lack of health insurance is not the only barrier to access. Providers may not be available or willing to provide services. Social issues, including poverty, drugs, substandard housing, and unemployment can prevent even the most determined families from getting the care they need or from just making it from one day to the next. The question, then, is how to support families who are confronted with this litany of problems day in and day out? One tried and true strategy for assisting families in need—a strategy that has worked worldwide, including in my State of Florida—is home visiting using Resource Mothers.

Resource Mothers build on the centuries-old concept of taking health care education and community resources into the home of pregnant women and their families. Almost every other developed nation with infant death rates far lower than the United States utilize home visiting as an integral part of their health care delivery systems.

A limited number of Resource Mothers programs do exist in this country, but not nearly enough as are needed. Resource Mothers provide outreach which is critically necessary to identify at-risk families, link them with the information they need to have healthy children, and guide them through the health and social service system maze. Resource mothers usually come from or live in the very communities they serve. They can be found in urban and rural communities, in hospital and clinic settings, in education and outreach programs, and in many other venues. They are trained and supervised by professional nurses, social workers and others.

If this all sounds like a simple concept, that's because it is! This is not rocket science—this is hands-on, people helping people technology. And it works because Resource Mothers do more than just lend a helping hand to families. They empower families to enhance their own health, well-being and futures.

Evaluations show that home visiting programs reduce low birthweight rates, increase the use of preventive health care services, reduce the incidence of child abuse and neglect, improve parenting skills and decrease the rate of school failure and welfare dependency. A 1990 GAO study on home visiting found that delivering preventive services in the home can reduce later serious and costly problems, including the $52 billion spent in the United States annually for neonatal intensive care of low birthweight babies.

Since its beginning, the National Commission to Prevent Infant Mortality has advocated the use of Resource Mothers as a key strategy for enhancing the health, well-being and self-sufficiency of at-risk families. Yet despite the proven effective-

ness of home visiting, no "system" of Resource Mothers has been developed in the United States, as it has been in other countries. Until today.

Today, I am pleased to announce, the Commission has launched its Resource Mothers Development Project. The project is a national campaign to increase the number and use of home visiting programs nationwide. We appreciate the support of Nestle USA and the assistance of INMED in the development of this project. Through the Resource Mothers Development Project, the Commission is providing technical support and information to the existing and new home visiting programs. The project includes a unique series of implementation, training and resource materials to help communities build their own Resource Mothers programs. In addition, the Commission has created a national information/referral service to enable programs to share information and strategies that can help communities and organizations improve their own home visiting initiatives.

We realize the goals of this project are substantial, but they are also vital if we are to make a meaningful difference in the lives of at-risk families and in our children's future. Especially with the Nation's attention turned to health care reform, the launch of the Resource Mothers Development Project could not be more timely. Resource Mothers offer this Nation, as they have so many others, a cost-effective, low technology way to maximize our health and social services, to link families with the care they need, to cut the bureaucratic red tape and to empower families to seek a healthy, productive future for themselves and their children.

When Resource Mothers visit pregnant women, new mothers or families, they not only provide them with critical information and emotional support, they also offer inspiration, encouragement and empowerment. They enable people to take charge of their lives and more confidently address the daily challenges that confront them. I have faith that when policymakers, businesses, civic organizations and others see the difference Resource Mothers make in their communities, we'll have home visits for every family that needs them.

Mr. Chairman, before I conclude my remarks, I would like to express my gratitude to you in particular for your leadership in promoting proven strategies to help families, such as the Children of Substance Abusers Act last year and the home visiting program that the legislation included. Now that the bill has passed, the Commission has been working to alert Members of Congress to the value of these programs and the opportunity Congress has to begin supporting them. Again, I want to thank the subcommittee for this opportunity to express my steadfast faith in home visiting programs as an effective strategy for helping at-risk families.

Senator DODD. Lynda Johnson Robb, of course, is no stranger to this institution at all. And let me just mention to my colleagues that we have known each other literally all our lives; growing up, our parents were great friends. So it is a distinct honor and privilege to have you before us and, as Governor Chiles has pointed out, you have done a tremendous job in your State of Virginia working on this with Chuck when he was Governor, and now on the commission, and you have given great insight and great first-hand experience to the issue. So we are pleased that you are here this morning.

Mrs. ROBB. Thank you, Senator Dodd. I think I probably tried to sell you Girl Scout cookies; I was very successful on the Hill.

I want to thank you all for being here today and to hear what we have to say. Just as Governor Chiles has gone from the Senate to the Governor's mansion, Chuck and I have gone the other direction, from the Governor's mansion to the Senate. But none of us have lost our concern and interest in this problem. Chuck started the Southern Governors' Task Force on Infant Mortality that got a lot of this going, and I am very pleased to be carrying that forward.

We have 24 Resource Mothers programs in Virginia, some that we started when Chuck was Governor, and then others that are now programs that are run entirely by volunteers, programs started by groups like Church Women United and the March of Dimes.

We also have some Resource Mothers programs in Virginia that deal specifically with drug-dependent women who are pregnant. Those are not just teenagers, but those are women who have been involved with drugs, and we have Resource Mothers programs just for them in a few specific cases, and I have visited some of those.

Health care reform is a very hot topic in Washington these days. Senator Dodd and Senator Wellstone and I visited with the First Lady this weekend and talked a lot about health care. I specifically was able to get in a plug for Resource Mothers because, just as my husband appointed me to work on infant mortality, Governor Clinton appointed his wife to that commission, and so we all worked on it then.

Insurance packages, benefit cards, copayments and access are all terms that are thrown around these days. These are all very important facets of health care reform and the movement we must deal with. However, to me, the most important ingredient is people: Who are the people in need, and who are the people who can help them? Regardless of what insurance system we devise in this country, it will boil down to the people who need and deserve the best that this great country can offer.

To that end, I am thrilled that we have launched the Resource Mothers Development Program. As Governor Chiles has explained to you earlier, it is a program that focuses on real people, that that's why I like it.

At-risk mothers and children often need the simplest things to help them toward a healthy life—a shoulder to cry on, an understanding soul to help them fill out forms, someone to go shopping with them and teach them about nutritional foods and how to cook them.

I know in southwest Virginia, another little aspect that sometimes we don't think about is that there are a lot of places where even though in theory, we have the services—things like Medicaid-eligible people—we don't have anybody to take care of them. In one of my trips to southwest Virginia, one of the programs told me that there was no doctor in the area who would deliver a Medicaid baby, but when they started the Resource Mothers program there, it gave that doctor the security that that woman would be having these support services and someone there to help her during her pregnancy, and he was willing to take the risk from his standpoint and actually help these women.

So it is not just what the resource mothers actually do; it is the other benefits, also, that accrue to the community. So I am very pleased with that aspect.

All of these things are part, I hope, of the health care discussions. They are very important in my book, and in actuality, they could make the difference between a healthy pregnant woman and one who ends up with a baby in an intensive care unit.

Individuals who are struggling deserve better than what we are currently offering them. And one person who is working in the trenches today, doing just that kind of work, is here to tell you how important resource mothers are. Now, I usually try to highlight somebody from Virginia, but since I am on the National Commission to Prevent Infant Mortality today, we have decided to have somebody from the District of Columbia. So I am very pleased to

be able to introduce Sarah Whye, who is a resource mother, sponsored by the Cooperative Extension Service of the University of the District of Columbia. She has worked in local communities for over 20 years, and she knows the daily problems and pitfalls that confront pregnant women and their children.

So I am very proud to introduce Sarah Whye.

Senator DODD. Sarah, welcome. You have at least one fan in the audience today.

Mrs. ROBB. Sarah has brought several of her resource mothers with her.

Senator DODD. By the way, thank you, Governor Chiles. We appreciate your being here.

I just want to ask Senator Wellstone if he has any opening comments.

Senator WELLSTONE. No. I appreciate it, Mr. Chairman. Let's just go on with the witnesses.

Senator DODD. Fine. Sarah, thank you for being here.

Mrs. WHYE. Thank you, and good morning.

I am Sarah Whye. I serve as a training technician in the infant mortality project sponsored through the Cooperative Extension Service of the University of the District of Columbia.

The primary objective of the infant mortality project is to help reduce the incidence of infant mortality in the District of Columbia. We work to encourage expectant mothers to obtain proper nutrition and appropriate prenatal care; abstain from the use of tobacco, alcohol and drugs, and to access and make use of all services applicable to the well-being of herself, the infant, and others in the family.

My primary tasks as a technician include recruitment and screening of applicants; interviewing participants; providing information and guidance in the use of information to participants; and collecting and summarizing data.

Personal contact with participants are made in places they congregate, such as health clinics, hospitals, churches, and in the familiar setting of their homes.

I believe that the personal support through the one-on-one contact and the technical information provided makes a big difference in the outcome of pregnancies and the quality of infant and early childhood care.

My experience in this project suggests that: many mothers need the kind of information and support that we offer; mothers want to know how to better care for themselves and their infants; when mothers learn the effects of tobacco, alcohol and drugs on the outcome of pregnancies, they will discontinue or at least decrease the use of them, and mothers need to learn how to seek access to and use information and services that are available.

I strongly believe that this kind of information and support should be made available to every mother.

And today we have with us an example of one our participants in the program, Ms. Wanda Cave.

Senator DODD. Wanda is accompanied today by her daughter, Michelle, probably the youngest witness we have ever had before the committee.

Ms. CAVE. Michelle can attest to healthy food.

Senator DODD. Wanda, we thank you for coming this morning. You are very gracious to be here.

Ms. CAVE. Thank you for having us—both of us.

The infant mortality program, I can only say what it did for me, but I know what it can do for everyone else, for every mother—not just teenage mothers. I am not a teenager. I am 38, and I have two children. I thought I knew everything about nutrition, but I didn't. And to have someone who can be with you even when you live in a city where your parents and relatives live, who will come—you know they are going to come; they are going to see you always, and they are always going to be there to answer questions for you—this will give you insight into things that you never even knew insight was there for.

They do everything for you. They make you feel wanted, and even when you're old and having a baby, they don't make you feel bad. You can do it. So I'm sure they are able to help the younger mothers, who are unfortunately younger mothers, know everything they need to know to keep our country going, and going a little better, let's hope.

This is my question for you, okay: Why do you have to have a meeting to discuss appropriating money for your future? I don't understand it. Maybe I'm lost, but aren't the children our future? Why do you have to think about whether or not you should give them money? Who is going to take care of you and me?

I don't know what else to say; I'm sorry.

Senator DODD. Yes, that's the question.

Ms. CAVE. I am still trying to figure it out—but then I guess that's why you're up there and I'm out here—I don't understand how it works.

Senator DODD. Well, believe me, we don't either, all the time.

Ms. CAVE. This is our future, and we should all invest, whether it is time or money or energies, however. We should all invest. We should all be resource persons.

Mrs. ROBB. In our northern Virginia program, one of our resource mothers was a teen mother herself and went through the program, and after she had such a successful outcome and had a healthy baby, she has now gone back to school at George Mason and is volunteering as a resource mother for other people in her community, because she knows how it saved her, and she now wants to help other people.

Senator DODD. I suspect they can probably make some of the best resource mothers, the ones who have been the beneficiaries of the program.

Ms. CAVE. That's right. I share information all the time, but it is only information I'm able to share because it was shared with me. We have to network.

Senator DODD. At the press conference we had earlier this morning, it was mentioned that the average weight of a child born to a mother who is part of the resource mothers program—do you remember that number? I remember the number you gave on Michelle.

Ms. CAVE. Seven pounds, 13 ounces. And my 23-year-old weighed 5 pounds, 3 ounces. I was 16, and I was 36 when I had Michelle. They are both great kids.

Senator DODD. I think someone mentioned the average weight was around 6 pounds, as I recall.

Mrs. WHYE. Six pounds, 7 ounces.

Senator DODD. Yes, which is substantially higher, of course, than younger women who aren't benefiting from the availability of proper nutrition and health care. So that number alone says volumes. If you have any doubts about the value of it, just look at the low birth weight infants.

And I always say to people, look, if you aren't impressed with the ethics or the morality of this, if the only thing that gets you today—and it seems that the only subject that seems to impress people today is cost—and if you are just interested in the fiscal implications of this, then consider the cost to the taxpayers of having low birth weight infants that are spending days and weeks, in some cases, in a pediatric intensive care unit. There is a tremendous cost associated with that, and by just making minor investments during the pregnancy of a woman to provide adequate nutrition to birth a healthy baby like Michelle not only on an ethical and moral basis, which ought to be justification, but just the cost saving ought to convince the skeptics of the value of it.

If I might, Mrs. Whye, I have just a couple of quick questions. First, I wonder what are some of the most difficult obstacles you face in attracting people to accept the resource mothers; what are some of the biggest obstacles you face?

Mrs. WHYE. Do you mean to pregnant women?

Senator DODD. Yes, getting the pregnant women to be receptive. What are the biggest obstacles you face in convincing them to be receptive to the program as you reach out to these women at risk?

Mrs. WHYE. I don't seem to have much of a problem in recruiting them into the program. Some are very skeptical as to what the program is all about, but I think you could say that may be one out of 10. But the majority of women that I approach who are pregnant, and if they are in qualification range, then we can bring them into the program.

Now, we must recruit women in their first trimester, which would be 3 months or under, and then they must be in Wards 5, 6, 7 or 8, because this is the geographic area that we work in in the District of Columbia.

But there isn't much of a problem to get them into the program.

Senator DODD. In your testimony, you said you try to convince women to stop smoking and drinking and substance abuse.

Mrs. WHYE. Oh, yes.

Senator DODD. Why would we just focus on the first trimester? Obviously, that is the best time to catch someone, but if you can convince someone who is even in the second and third trimester, it seems to me you minimize the possibility of these difficulties.

Mrs. WHYE. Yes, that's true, but the first 3 months are the most crucial.

Senator DODD. I agree with that, but you are not limited to that, are you?

Mrs. WHYE. No, no. We work with them through their pregnancy on through until the child is 1 year old or over. We do not cut off per se, but we have certain areas that we can work in. We cannot take the whole city. We cannot include the whole city.

Senator DODD. Yes, I understood that. But you cannot recruit a mother beyond the first trimester of her pregnancy?

Mrs. WHYE. Not into our program, but we do talk to them, and we do give them literature and educational materials.

Senator DODD. Whose idea was it to limit it to the first trimester?

Mrs. WHYE. Well, this is when the mother really needs the most important care.

Senator DODD. Yes, I understood that——

Mrs. WHYE. But we must work with them from the 3 months on through to the 9th month and on through until after their baby is 1 year old.

Senator DODD. I guess all I'm saying is that if you run into someone who is in the second trimester or even the third trimester——

Mrs. WHYE. We will give them educational material, but we do not have enough resource mothers to take care of all of these pregnant women, so therefore, we have to screen them. But we do give them educational material, and we do give them advice.

Senator DODD. OK.

Mrs. ROBB. That is one of the problems, Senator Dodd. We don't have enough money to treat all the people that we know need our services. Now, in our resource mothers programs in Virginia, we highlight teenagers. We know that there are a lot of women who are not teenagers who need our services desperately. But with a small amount of money, we have just decided that that's where we get the most bang for our buck.

And it is the same problem in Mrs. Whye's program, I'm sure—she has to target a certain area, and she has had to target certain times in that pregnant woman's life.

We do know, however, that if we can get that prenatal care to the woman at any time that she is pregnant, it is going to improve her. One of the things that we are talking about also is self-esteem; it's not just the physical part, it is also the self-esteem that you give that pregnant woman. You try to teach her how to take care of herself and her baby. That is very important, and any time we can get that to them, we'd like to—one of the things we're asking you for is some support so that we can spread this everywhere in this country and so that we can do it for the people who need it and not just those who happen to be teenagers or who happen to be in the first trimester or who happen to live in a certain part of Washington.

Senator DODD. What other States—obviously, we know about Virginia, where you did a great job with Chuck promoting the 24 programs in your State—but what is going on generally around the country in other States?

Mrs. ROBB. Well, in the southern task force that we did, we found that all the southern States have more problems than the rest of the country. But as you know in your own State, there are pockets, there are terrible places. In Connecticut, the home of the insurance industry, you have thousands of babies who are dying. So it is not just States. Sometimes, it is specific rural areas.

In Appalachia, for instance, we know that access is a great problem. We don't have the doctors there or the medical people who can deliver the babies; we don't have the health care providers, and we

don't have the transportation to get the mothers to the clinics or to the places where they can get the prenatal care.

We know that there are inner cities where there are services available, not very far away, but the women do not know that they need to get in and get the services; they don't know how to access the system.

In one city in Virginia that I visited, the resource mothers there said, "When we started this program, we thought we were going to be dealing with street girls," girls who had no support, and what we found was that so many of the young women we were dealing with were people who had been thrown out of their homes by their families, and these young people really didn't know anything about how to get in the system, how to get care, because they had always just gone to their family doctors, and now their families had turned them away, and without that resource mother, they wouldn't know where to go.

So it is so important that you have that person there who says, "I care." And as a Nation, I think we do care, and we need to be concerned with that.

Senator DODD. I understand; there is no question. I'm just trying to get an idea of some of the funding sources. How about the private sector; have they been helpful?

Mrs. ROBB. Not as much as we would like, but for instance, we have a program in Harrisonburg, VA that was started by Church Women United, by the local hospital, and by the women's health center. The March of Dimes has been very helpful in starting programs. Some of the programs that get maternal and child health funds have also gone to local businesses. Dominion Terminals in Tidewater has been very helpful in matching.

Across the country, we have home visitors and resource mothers programs all over. Some of them get State funding, some get local city funding or local county funding. They have turned to their medical people there to give them some free services. We'd like to have more. We are trying to get groups like the March of Dimes, the Kiwanis, the Jaycees, the Rotary, and a lot of those other groups involved, and we have in specific instances.

Senator DODD. Good. Let me turn to my colleagues. I didn't mean to take up so much time.

Senator Coats.

Senator COATS. Wanda, in response to your question why is this hearing necessary, we have hearings going on all over the Hill. There is a limited pot of money available, and there are more demands on that money than there is money available. So we have all these hearings going on, and in every hearing room all over the Capitol, we have witnesses saying, "Give us this share of the resources." So what we are trying to do here is to highlight the importance of this program and why it is a wise investment.

But I can guarantee you one thing—there isn't a panel of witnesses anywhere in any hearings today anywhere on the Hill that has a witness as charming and as captivating as your young daughter, Michelle. So we have a great advantage in this hearing today that no other hearing can match.

I know there are variations of this program around the country. We have a significant effort underway in Indiana, particularly in Indianapolis.

Mrs. ROBB. It's a big program in Indianapolis.

Senator COATS. My understanding is that it is not formally associated with it, but it is the same concept.

Mrs. ROBB. Absolutely. We don't think that the government has to do everything—the Federal government, the State government, the local government. What we want to do is be in partnership with you. We want you to help us get these programs going and help support them in different places, but not to always be the total funding. We know that we all need to work together on this.

Senator COATS. How do you go about recruiting volunteers to participate in the program?

Mrs. ROBB. What we have done, and what Nestles has helped fund us and allowed us to do is to make this information available. We have this new boo, the resource mothers book, that talks all about these questions: Where do you go for funding? How do you get a program going? How do you recruit.

Now, for instance, one of the things that we did was we talked to groups in Virginia about sponsoring resource mothers, about actually running them. For instance, in northern Virginia, we have a program that works with Hispanic teenagers that is run by the YMCA in Fairfax. They then go and try to find women from within the Hispanic community particularly, but other people, too, who then can relate to these young people that they are dealing with. I told you earlier there was one who was actually a teen mother herself. It has been a very successful program. Sometimes, they get them through ads in the paper, telling about resource mothers. We have a lot of people who have just volunteered.

We have a program that has just started that the National Catholic Women are doing, and they put out an ad or an information about it, and more than half the people who turned up were not Catholic who volunteered to work in the program and who wanted to learn.

So what we have been able to get from this grant is the information to put in a training manual, so if you want to start a program, we can say, "Here it is. Now, you look in there, and this book will tell you how to raise the money, how to recruit the people, how to get it started, how you might go about getting people involved in your community." And then we have something that will actually teach the resource mother about how to work with somebody who is drinking or smoking or has a drug problem and how dangerous that is. It is a training manual for the resource mothers to educate them to be good resource mothers.

Senator COATS. And this was put together with a grant from Nestles; is that right?

Mrs. ROBB. Yes. We have to booklets. One is for how to start a program, and one is actually the educational material for the resource mother, because you know, we are teaching laypeople. One of the things we are talking about is how we can give everybody the opportunity to live up to the best that God gave them, and we aren't looking for doctors and nurses to run all of these programs; we can't afford it—the country can't afford it. So what we want to

do is find women within the community whom we can teach these skills to, and they can go out and mentor other people.

Senator COATS. So you recruit the volunteers, and you bring them in for some type of training.

Mrs. ROBB. Yes. Now, for instance, we have a program called The Elizabeth Project, named after Elizabeth, the mother of John the Baptist—and she nurtured Mary when she came to her as a pregnant teenager, unwed. In that program, I think they have 12 weeks, and they sign a contract. The "Elizabeth" signs a contract saying that she will go to this training session once a week for 12 weeks, and then also during that week, she will meet with her "Mary" and counsel her "Mary." And the "Mary" signs and promises that she will come to that training program once a week, and then once a week, work with her "Elizabeth." And during this time, they call each other about all sorts of things, and just try to be supportive. "I have this little pain here; does that mean something terrible?"—just trying to talk to them about the importance of good nutrition and about how to take care of themselves so they can have a healthy baby.

Senator COATS. What type of administrative structure do you typically need for a program, for an average-size city? I realize——

Mrs. ROBB. It depends on how many resource mothers you are going to have and how many clients. In one case, we have one resource mother, and she is helping to mentor maybe as many as 10 teenagers. In other cases, for instance, The Elizabeth Project, it is one-on-one; it is one nurturer and one receiver.

Senator COATS. But what administrative structure do you need to put the program together? You need somebody in the office to help with recruiting and fundraising and training and so forth. Typically, is there a ratio of the number of caseworkers to clients?

Mrs. ROBB. It is really hard; I don't know the exact numbers because, of course, some of them are run all by volunteers, and it depends on what services you have donated, of course. For instance, if you already have the hospital underwriting some of the costs for an office and clerical personnel, obviously, it doesn't cost you as much.

Senator COATS. It sounds like there is a lot of flexibility in the program, and you let communities tailor it to whatever resources are available and whatever structure they can feasibly put together.

Mrs. ROBB. That's exactly what it is. For instance, just in the programs that we actually give MCH money to in Virginia, we have health districts that are running them, we have the YMCA, we have the office of human affairs in Newport News, we have the Norfolk State University Nursing School running a program. It just depends on whom you find that is interested and willing to do the parenting.

Senator COATS. Thank you very much.

Thank you, Mr. Chairman.

Senator DODD. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

Mrs. WHYE. Pardon me. May I say something? I don't have all the answers because I am a resource mother, but the director of

the infant mortality project is here, Dr. Lord, and she would have answers to some of the more specific questions.

Thank you.

Senator DODD. Thank you, Doctor, for being with us. Why don't you tell us your full name?

Dr. Lord. Lillie Monroe-Lord. I am director of the infant mortality nutrition project, with the cooperative extension service at the University of the District of Columbia.

Senator DODD. Terrific. Thank you for being here with us.

Go ahead, Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

I have two quick comments and then two questions, and I'll try to stay within a tight time frame.

First, I would like all of you to know, since you have been down in the trenches doing this work, that as a former teacher—and I think most teachers would say this as well—actually, this is the most important educational program in the country, that every mother expecting a child has a diet rich in vitamins, mineral and protein. I mean, if that doesn't happen, a lot of children are born and just don't have the same chance to learn.

My second point is that it occurs to me, Mr. Chairman, that one of the things that is so timely about this testimony is that I believe that whatever we do vis-a-vis health care, much of the focus will be community-based and more decentralized in the delivery of it, and this is a good example of where we talk about home-based health care, long-term care, people with disabilities, older Americans, trying to do block nurse programs, people in the neighborhoods working with a nurse backed up by doctors out in the community; in some ways, this is exactly the same approach. So I think it is very, very relevant to some of the delivery questions that we are going to be dealing with.

Now, my questions. First of all, Mrs. Whye, could you talk a little bit—Lynda Johnson Robb mentioned this point, but I wondered if you could expand on it—above and beyond the whole issue of nutrition and the condition of a woman expecting a child, what about the whole issue of self-esteem and dignity; is there more that happens than just sort of, if you will, meeting the economic needs for women in the program that you see?

Mrs. WHYE. Yes, this is true. They need more than just to talk about nutrition. We go into the homes, and we give them the necessary information for them to be able to deal daily. But a lot of times, before we can get into teaching them, we have to refer them to other centers for help—lack of housing, lack of clothing, lack of food, no transportation. There are many things that we have to get to before we can get to the meat of the program, yes.

Senator WELLSTONE. That actually goes to the second question I have. In other words, I am trying to figure out—as much as I respect the program—and please, don't take this the wrong way—sometimes when I hear you describe it, it sounds like everything is being done for the women.

Mrs. WHYE. Oh, no.

Senator WELLSTONE. And I'm trying to get you to talk a little bit more about it, because it seems to me there must be more than just having a resource mother come in and in a sort of condescending

way, patting an adult on the head and saying, "Do this, this and this." That's not what you're talking about, right?

Mrs. WHYE. Right.

Senator WELLSTONE. Can you give us a feel for your interaction with people?

Mrs. WHYE. We have to go in, and we talk with them, and before we can even get to the lesson, most of the time, we have to refer them for help. Some don't have homes to live in, period, and we have to refer them somewhere where they can find a home to live in, or we put them into a shelter—and we teach in the shelters. We go to these shelters and work with these ladies in shelters.

Senator WELLSTONE. So are resource mothers advocates?

Mrs. WHYE. Yes. We have to go and do all of these things, but we do not give them direct—we just refer them. But we go out to give them lessons. We teach prenatal lessons in their homes.

Senator WELLSTONE. Here's my question——

Mrs. WHYE. I guess I don't understand.

Senator WELLSTONE. No. You are giving a great answer. I'm the one who is goofing up on the question. I did a lot of organizing with low and moderate-income people, mainly in rural areas. Now, a resource mother is visiting with a woman and talking about the importance of a good diet; right?

Mrs. WHYE. Yes.

Senator WELLSTONE. But that woman doesn't have the money to afford a good diet or, talking about the importance of health care, that woman doesn't have the accessibility to decent health care, or talking about the importance of your children not eating lead paint, but that's what that woman has in her apartment.

How do you—do you ignore all of that, or somehow, does what you are doing with the people you are working with relate to that? Do you see what I'm getting at?

Mrs. WHYE. Yes, I understand. This is why I say we have a referral system. We have a crisis center where we send our pregnant women, where they work directly with the resource mothers. I think it is called the United Planning Organization in the District. They work right along—they make home visits the same as we do and backtrack if needed. If a person does not have a home, they will try to steer them in the right direction.

Senator WELLSTONE. OK.

Mrs. ROBB. We try to teach them about how to survive. We teach them that they are important and that they can take care of their child. In the Virginia programs, we have found that where we've had the resource mothers programs, the young people have stayed in school or gone back to school. That is very important. I think 67 percent have gone back to school or stayed in school. And you know how important it is if you can get that education.

Senator WELLSTONE. The resource mothers themselves basically come from the communities and have gone through the same kind of struggles as the people they are working with—is that correct, or not?

Mrs. ROBB. They don't have to. We look for women within the community that we can get to be resource mothers. But for instance, in our program here in northern Virginia, we are dealing

with Hispanic teenagers, and we don't have as many available that we can get from that community. But we still try.

Senator WELLSTONE. I would think that would be critically important to the way it really would work.

Mrs. ROBB. Because you want to be culturally sensitive, also, besides just speaking the language in that case.

Senator WELLSTONE. Now, my last point, because we need to move on. This is to Wanda. I want to go back to the question that you raised about why do we have to talk about this when it seems so obvious—and you said it in a very strong and eloquent way—that, my God, if this isn't a priority, this kind of investment in women and children, what is a priority. And I think Senator Coats gave you a very honest and heartfelt answer.

I want to just put another, if you will, twist to it—and this is just my appeal, Mr. Chairman. We had this conversation the other day—you may not remember it—but I think that those people who argue that deficit reduction is the only domestic public policy goal today—cut and reduce the deficit, period—I think need to listen to your testimony, because to say that that's the only thing we must do is to put off exactly what you are talking about, and for how much longer are we going to put this off. I just want to make that point, because you make this discussion not abstract.

I'm done, Mr. Chairman.

Senator DODD. Thank you.

Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

Most of my questions have been answered, but perhaps to Mrs. Whye or Dr. Lord—I am curious—do you work with the Public Health Service, for instance, in recruiting those who serve as resource mothers? I am a strong supporter of home visiting, and I think that these are important initiatives, but is there some criteria you bring, other than just training them before they start out? Do they work with the Public Health Service? If someone says they have a pain, how do they know how to answer?

Mrs. WHYE. Most of the participants that I recruit, I do directly in the DC. General Hospital, plus door-to-door, but the majority of them are right at the hospital. We work directly with the hospital.

Senator KASSEBAUM. For the personnel who go out to work in the home?

Mrs. WHYE. No. I recruit and go into the home.

Dr. Lord. I can answer that question. In reference to the recruitment of resource mothers, we actually recruit them directly from the community in which they live. Currently, the resource mothers that we have now, have been with the project for 20 years, but in terms of the DC. Healthy Start Project, we have just recently recruited 20 resource mothers from the community, and they are going to work within their community in terms of providing services and they are going to be linked with public health nurses in the hospitals for follow-up.

Senator KASSEBAUM. That was what I was wondering, because it seemed to me there needed to be a link there somehow with nursing or nutritional experts when you work as a resource mother, going in to visit in the homes.

Thank you very much. It's a very impressive program.

Mrs. ROBB. We all know that all of our public health centers are stretched, and we want it to be that the paraprofessional can come in, bring the young person or pregnant woman into the public health system and have them understand it and, yes, be an advocate. Somebody asked are you an advocate, and yes, we are. We try to help these pregnant women learn what they can do to take care of themselves and their children.

Senator KASSEBAUM. I think that's a good way to put it, a paraprofessional, perhaps, for the Public Health Service. I think that helps to clarify the connection, which would seem to me to be very important for both sides.

Senator DODD. Thank you all very, very much. We appreciate your being here.

Wanda, we want to thank you and Michelle. It's not easy to come and talk about your own circumstances, and we are very grateful to you for doing so.

Lynda, as always, we are deeply appreciative of your work and your efforts. And Mrs. Whye, we thank you immensely for the work you have been doing. The District of Columbia is very lucky to have you in those three wards you work in. I'm sure there are a lot of healthy children today who can look to you and others who have worked with you over the years for that wonderful accomplishment. So we thank you.

Senator WELLSTONE. Mr. Chairman, if I could just have 10 seconds to thank everybody, but also to make an apology. I have to go to a health care gathering that I promised to attend, and I didn't want anybody to think it is lack of interest or lack of commitment. I'm sorry about that.

Senator DODD. Not at all; thank you, Senator.

Our next panel includes Joanne Woodward, Lisa DeMatteis and Gail Higgins. And as our three witnesses come to the table, let me tell all of you what an distinct honor and privilege it is to have Joanne Woodward with us this morning. She is a constituent of mine and a friend, first and foremost; but second, she has dedicated a good part of her life to worthwhile causes.

I was privileged on Monday evening along with many others to view a movie made for television, called "Blind Spot," and I don't mind being a propagandist here at all, but on Sunday night, May 2, at 9 p.m., on CBS—take out your pencils and paper, and write this down—"Blind Spot" will appear as a movie made for television. And aside from promoting a product made by a Connecticut constituent, it is an extremely important movie, beyond entertaining, which it is, because it is so effective in that it takes a family—and a family that you would not necessarily expect to be in this situation—that is suffering from a lot of stress—and I won't reveal the plot here—and shows how it finds the resources to deal with the substance abuse problem, in this particular case.

I think Anne Frank told us far more about the Holocaust than all the documentaries; "Roots" did more to educate people about the problems of racial discrimination and the roots of it in this country than all of the wonderful other programs that were put together over the years; and I think this movie, "Blind Spot," will do a great deal in educating people about the problems of substance abuse and the pressures that families face—and you don't have to be poor

and come from an inner city to have these problems. So we are deeply grateful to you, Joanne, for being here this morning to offer some insights into this area that you bring not only because of your professional experience, but also personal ones as well. The Scott Newman Foundation is one that you and Paul have been involved in for years, and I'll let you talk about that at the appropriate time.

Lisa DeMatteis is also a constituent, and we are very appreciative of her time. She is the program director of the Women and Children's Center in Middletown, CT. And when you have seen the movie on Sunday night, the center that is in the movie is modelled after Lisa's center in Middletown, CT, one of the first in the country. It has done a remarkably fine job in finding ways to educate the public about how successful programs like yours can do so much for people in need.

Gail Higgins is the beneficiary in a very real sense of this effort. She is a successful graduate of the center's program, and she is going to tell us about her own personal story and how the center helped turn her life around. So we are deeply grateful to you as well for coming here this morning, Gail. It is not easy to be in a public forum and talk about your own personal circumstances, but please know that you are telling a story that could be told thousands and thousands of times over. Unfortunately, we need more of those stories, and hopefully with some effort here, we can expand some of these good projects across the country so that others can receive the same benefits that you have.

So we thank all three of you for being here this morning, and Joanne, we'll begin with you.

STATEMENTS OF JOANNE WOODWARD, SPOKESPERSON, AMERICA BELONGS TO OUR CHILDREN CAMPAIGN, WESTPORT, CT; LISA DeMATTEIS, PROGRAM DIRECTOR, CONNECTIONS WOMEN AND CHILDREN'S CENTER, MIDDLETOWN, CT, AND GAIL HIGGINS, MIDDLETOWN, CT

Ms. WOODWARD. Thank you, Senator Dodd, Senator Coats, Senator Kassebaum, for letting us come here and talk about another element of this problem that we all face, that we have listened to on the other panel.

We want to talk about the problems of babies exposed in utero to drugs, alcohol, and this problem obviously is going to attack all of us and very soon, because these babies are now maturing—the ones that survive are maturing—and growing up and entering our school system, and the difficulty is already becoming an enormous problem.

In October 1990, we at the Scott Newman Center for Drug Abuse Prevention and Education, and Very Special Arts, Jean Kennedy Smith's group, joined forces to work on a project called "America Belongs to our Children," and one of the most important elements of addressing that problem is to foster national support for the provision of needed services for pregnant women who have alcohol and substance abuse problems, and their children and their families. It is imperative that this be addressed now because what is happening is it is perpetuating a cycle, constantly a cycle, of the pregnant woman with drug abuse who isn't taken care of, who then turns to child abuse, child neglect, and the cycle just continues to recur.

When we started this whole project, we all decided that what we needed to do was to find in our own way a way of getting to the public, getting this message out to the public. Obviously, because I am an actress, the first thing I thought of was film. I have had some successes with other films, one notably on Alzheimer's, that I did as a dramatic piece that brought forth a lot of talk and knowledge for people on the subject which they were not tremendously well-acquainted with, and we hope to do the same thing with this film.

I was very lucky to engage Robert Howme, Dick Welch from Hallmark itself, and CBS, in this effort, and together we worked on this film, called "Blind Spot," which as Senator Dodd has said will be on Sunday at 9:00 on CBS, and I hope as many people as possible will be able to view it.

Senator COATS. That's Sunday, May 2nd, isn't it?

Ms. WOODWARD. Sunday, May 2nd. Thank you, Senator Coats.

Senator DODD. And that's 9 p.m. Eastern Standard Time.

Ms. WOODWARD. Oh, yes. OK.

Senator DODD. We just want to get this out here, in case anyone is missing the point.

Ms. WOODWARD. Yes. Please, don't miss it. This film, as the Senator says, deals with the effect on one family of drug abuse during pregnancy and the difficulty in finding a way of dealing with this as a pregnant woman and then as a woman who has a baby who is affected by drugs. In this case, the family is not an inner-city family, because we find that it is too easy to say that, oh, well, that's a problem that exists over there. This is not true. This problem exists everywhere and in every family. So that is why I purposely set it in this setting.

And what happens, of course, in the film is that they do find such a place, which is a home setting recovery facility. We based this facility on the Women and Children's Center in Middletown and, as Senator Dodd says, it is wonderful that we have this place. It is a remarkable facility.

I am just sad that it is the only one we have in that State, and I wish there were 100 in our State and thousands all over the country, because for this particular aspect of the problem, it has proven to be the most important and the most successful way of dealing with the problem and helping these mothers to become mothers, to learn nurturing skills to be able to deal with their babies, in order to help these babies recover—because they are recoverable; they are not throw-away babies, but they need very special parenting, and they need very special care.

When the problem is this deep, it is very difficult to do it in any other way except to have the mother and the child there in a safe space and with people who are able to help them learn these skills and learn skills to be able to get out into the work force and to take care of that child.

What I would like to do with your indulgence is to show a very short clip from the film which addresses this particular aspect of the film. It is a scene which takes place in the home facility and deals with the girls who are there.

[Videotape shown.]

Senator DODD. Now you see why you've got to watch this program on Sunday night.

Ms. WOODWARD. I certainly hope everyone will. As I say, this is just an element of it, but it is to me the most important element, and it is why I did it.

I'd like to introduce now Lisa DeMatteis, who is the head of the center and the one who really inspired us to do this. She was our inspiration, and the group was our inspiration.

Ms. DEMATTEIS. Thank you, Joanne.

Senator Dodd, members of the committee, I am Lisa DeMatteis, program director of the Connections Women and Children's Center in Middletown, CT. With me today is Gail Higgins, a successful graduate of the Women and Children's Center. Gail gave birth to our very first baby at the center, and I am very proud to have her with me today.

Thank you for this precious opportunity to share with you information about our program for substance abusing pregnant women and their children and the courageous women who find their way to recovery from their alcohol and drug problems with our help.

The Connections Women and Children's Center is a long-term residential treatment facility for pregnant substance abusers 18 years of age and older and their children. Operated in a large restored house in a residential neighborhood setting, our program is licensed to accept up to eight women and seven children. Women must be pregnant in order to be eligible for admission to our program, and they are permitted to bring up to two children to live with them at the program while they are in treatment. The duration of their treatment is 9 months to 1 year, with most staying the full year.

Women may enter the program at any stage of their pregnancy. Waiting lists can be at least 4 to 5 months long. Unfortunately, the shortage of services demands that if a woman gives birth while on a waiting list, she is no longer eligible for the program unless she becomes pregnant once again.

While the women who enter our program come from all socioeconomic backgrounds, they have certain characteristics in common. A typical woman entering our program has come from a dysfunctional family setting. Most have been physically, sexually and emotionally abused. Many have been raped, institutionalized, and have turned to prostitution. The emotional trauma is so deep for these women that they have formed a barrier of denial about their problems and see their dysfunctional environment as normal.

Most of our residents started using and abusing alcohol and other drugs at an early age to escape the misery of their abusive environment. These women for the most part had no childhood, no positive role models, and no opportunity to acquire the basic skills to provide a normal, healthy lifestyle for themselves or their children. Many of the women in our program have one or more children in foster care or the care of a relative or friend for reasons related to their substance abuse problem.

Unfortunately, these same conditions often existed for the mothers of the residents. Our residents, unless habilitated to a healthy lifestyle, often impose the same conditions upon their own children, thus creating a generational cycle of abuse that leads to addiction.

There are so many barriers that keep pregnant women from seeking treatment today. Lack of child care, transportation and housing, as well as a severe shortage of programs suitable to meet their complex needs, are among the most prevalent. Fear of losing custody of their children often forces women to hide their alcohol and drug abuse problems and prevents them from seeking prenatal care.

The Connections Women and Children's Center is one of the first residential programs established in Connecticut that is specifically designed to overcome these barriers and provide the comprehensive services needed by substance abusing pregnant women and their children. Funding for the program is provided primarily by the Connecticut Alcohol and Drug Abuse Commission. Other funding sources include the State Department of Children and Youth Services, the City of Middletown, United Way, and March of Dimes.

Even though the Connections Women and Children's Center has these funding sources, we are still struggling to maintain adequate funding. Lack of full funding for existing services is a major threat to our continued operation and for other programs like ours. Lack of funding also prevents establishment of new programs which are so desperately needed. We are committed to working with our State and Federal governments to assure long-term, stable funding for programs.

The types of services that we provided at the center include individual, group and family therapy; drug education and prevention; prenatal and postnatal care in cooperation with local medical providers; parenting and social living skills; adult education and vocational rehabilitation services; diagnostic services and Head Start for the children; and re-entry skills, including accessing housing, day care and employment.

Our mothers learn at the center how to provide their children with a healthy, loving home. They acquire health, nutritional and personal hygiene skills. They learn about AIDS and other sexually-transmitted diseases. And they learn how to build healthy relationships with their husband, significant other, and family members.

Much work to achieve family reunification is done with women in our program who have lost custody of their existing children. We work closely with the State Department of Children and Youth Services, the courts and the custodial caretakers of the residents' children. Residents, their children and other family members do receive group and individual family therapy counseling aimed at reuniting the family.

We also provide as part of our discharge planning linkages with community support systems which are so desperately needed, such as Alcoholics Anonymous, Al-ANON, Narcotics Anonymous, Cocaine Anonymous, the Visiting Nurses Association, and individual therapists, as appropriate for their needs. Aftercare at the program is also provided in the form of group meetings and peer counseling. The main purpose of these linkages is to continue to assist the client to maintain sobriety.

Gail, who is with me today, has become a peer counselor as part of her discharge planning, and she comes to the center biweekly, and she runs groups for the women in residence.

I can't begin to tell you what that is like not only for Gail, but also for the women in treatment, who believe that their life is hopeless, that they can't get their life back together, and to see someone like Gail come back as a wonderful role model, to encourage these women to continue in the program is most remarkable.

To date, we have had eight successful graduates, and they are all clean and sober today, Gail being one of them. This proves to me that treatment programs like the one that I run are so desperately needed throughout the entire United States.

We desperately need your help. Abuse of alcohol and other drugs is one of our Nation's most serious public health problems, generating huge demands on health care and other public systems, and causing substance abusers and their families and friends untold pain and suffering.

Our substance abuse treatment program is woefully inadequate. Shortages of available care are prevalent in many areas of our country. In some cases where treatment slots and beds are available, barriers to access that treatment are often insurmountable.

I am so pleased today to introduce to you Gail, who stayed at the center for one whole year, and who worked on so many issues. She had so many roadblocks in her way, and she moved each and every one of them. Not only did she give birth to a very healthy baby, Eddy, who was 8 pounds and 2 ounces, but she was reunited halfway through her treatment with her 14-year-old daughter, whom she was told she would never gain custody of again, and she did that, among many other wonderful things.

So at this time, I would like to say thank you and introduce Gail.

[The prepared statement of Ms. DeMatteis follows:]

PREPARED STATEMENT OF LISA DEMATTEIS

Senator Dodd, members of the committee, I am Lisa DeMatteis, program director of the Connections Women's and Children's Center in Middletown, CT. With me today is Gail Higgins, a successful graduate of the Women and Children's Center. Thank you for this precious opportunity to share with you information about our program for substance abusing pregnant women and their children and the courageous women who find their way to recovery from their alcohol and drug problems with our help.

The Connections Women's and Children's Center is a long-term residential treatment facility for pregnant substance abusers, 18 years of age and older, and their children. Operated in a large restored house in a residential neighborhood setting, our program is licensed to accept up to 8 women and 7 children. Women must be pregnant in order to be eligible for admission to our program. They are permitted to bring up to two children to live with them at the program while they are in treatment. The duration of their treatment is 9 months to 1 year, with most staying the full year.

Women may enter the program at any stage of their pregnancy, but we prefer to see them enter during their first trimester. Waiting lists can be 4 to 5 months long. Unfortunately, the shortage of services demands that if a woman gives birth while on a waiting list, she is no longer eligible to enter the program, unless she becomes pregnant again.

While the women who enter our program come from all socio-economic backgrounds, they have certain characteristics in common. A typical woman entering our program has come from a dysfunctional family setting. Most have been physically, sexually and emotionally abused. Many have been raped, institutionalized and have turned to prostitution. The emotional trauma is so deep for these women that they have formed a barrier of denial about their problems and see their dysfunctional environment as normal. Most of our residents started using and abusing alcohol and other drugs at an early age to escape the misery of their abusive environment. These women, for the most part, had no childhood, no positive family role models, and no opportunity to acquire the basic skills to provide a normal, healthy lifestyle

for themselves or their children. Many of the women in our program have one or more children in foster care or the care of a relative or friend for reasons related to their substance abuse problem.

These same conditions often existed for the mothers of the residents. Our residents, unless habilitated to a healthy lifestyle, often impose the same conditions upon their own children, thus creating a generational cycle of abuse that leads to addiction.

There are many barriers that keep pregnant women from seeking treatment. Lack of child care, transportation and housing, as well as a severe shortage of programs suitable to meet their complex needs are among the most prevalent. Fear of losing custody of their children often forces women to hide their alcohol or drug problems and prevents them from seeking prenatal care.

The Connections Women's and Children's Center is one of the first residential programs established in Connecticut that is specifically designed to overcome these barriers and provide the comprehensive services needed by substance abusing pregnant women and their children. Funding for the program is provided primarily by the Connecticut Alcohol and Drug Abuse Commission. Other funding sources include the State Department of Children and Youth Services, the City of Middletown, the United Way, the March of Dimes, and Newman's Own.

Even though the Connections Women's and Children's Center has these funding sources, we still are struggling to maintain adequate funding. Lack of full funding for existing services is a major threat to our continued operation, and for other programs like ours. Lack of funding also prevents establishment of new programs. We are committed to working with our State and Federal Governments to assure long-term stable funding for programs.

Long-term residential care is needed by these women to overcome the unfortunate circumstances of their former environments. At the Connections Women's and Children's Center, they acquire self-esteem and learn positive parenting, social and life skills needed to break their cycle of addiction and integrate successfully into the community.

We provide: individual, group and family therapy; drug education and prevention; prenatal and postnatal care in cooperation with local medical care providers; parenting and social living skills; adult education and vocational rehabilitation skills; diagnostic services and Head Start for children; and re-entry skills, including accessing housing, daycare, and employment.

Our mothers learn how to provide their children with a healthy, loving home. They acquire health, nutritional and personal hygiene skills. They learn about AIDS and other sexually transmitted diseases. They learn to build healthy relationships with their husband, significant other, and family members.

The Connections Women's and Children's Center teaches its residents structure and responsibility. Residents are required to be responsible for the care and behavior of their children living in residence with them. They plan and prepare nutritional meals and eat together as a family at least twice daily. In order to earn privileges, residents must adhere to their personal treatment plans and program rules, attend all required group and individual counseling sessions, show positive behavior and treat others with respect.

Much work to achieve family reunification is done with women in our program who have lost custody of their existing children. We work closely with the State Department of Children and Youth Services, the courts and the custodial caretakers of the residents' children. Residents, their children and other family members receive group and individual family therapy counseling aimed at reuniting the family.

Upon discharge, linkages are made with community support systems. Our mothers are directed to Alcoholics Anonymous, Visiting Nurses Association, and individual therapists, as appropriate for their needs. Aftercare at the program is also provided in the form of group meetings and peer counseling. The purpose of these linkages is to continue to assist the client to maintain sobriety.

The Connections Women's and Children's Center has been in operation since September 1991. During that short time we have had 24 admissions, of which 8 have successfully graduated, 8 are currently in residence, and 8 left before completion of the program.

Of the 8 successful graduates, all are clean and sober today. Seven currently participate in our aftercare program, and the eighth is employed full-time and living independently with her four children.

These successes indicate to me that we are taking the right approach, but we desperately need your help. Abuse of alcohol and other drugs is one of our Nation's most serious public health problems, generating huge demands on the health care, and other public systems and causing substance abusers and their families and friends untold pain and suffering. Our substance abuse treatment service capacity

is woefully inadequate. Shortages of available care are prevalent in many areas of our country. In some cases where treatment slots and beds are available, barriers to access that treatment are often insurmountable.

These issues are complex and in order to achieve and maintain successful recovery, a comprehensive approach must be taken. We need more programs that provide the full continuum of care for substance abusers, not just pregnant women, but for all men and women who need treatment for this disease. It is essential to provide the comprehensive services that are needed to treat the whole person and enable him or her to achieve and maintain sobriety. A comprehensive approach to treatment and prevention, with access for all who need services, saves lives, saves families, and saves medical and social costs. Thank you.

Senator DODD. Thank you, Gail, for coming.

Ms. HIGGINS. Thank you. Good morning, Senator Dodd, members of the committee. I am very happy and proud to be here, and if it were not for the Women and Children's Center, I would not be here; I don't know if my son would be here, and I have no idea where my daughter would be. But through the center, we are here, and we are here to stay.

A few years ago, I had no home, no future; my daughter was living with my sister, because I had nowhere to keep her. I then discovered I was expecting another child. I didn't know where to go or what I was going to do. I just didn't think there were any answers.

Through the community health center, I was referred to the Women and Children's Center. I was interviewed by Lisa and accepted into the program. I entered the program in September, not even sure that I really wanted to be there, but it was better than being nowhere.

In October, my son was born, and that's when I knew I was in the right place. I wasn't sure—I kept asking myself why me; of all the women out there who need this chance, how did it happen to come to me? And I am beginning to see some of the reasons why.

After not having my daughter for a little over a year, sometimes it still overwhelms me that now I have both my children with me. I was very irresponsible while I was active, because when you are addicted to any form of substance, it becomes the most important focus in your life. It is a terrible sickness, and it is one that we definitely need to devote much time and attention to.

There are other treatment facilities available, but they would not have brought me to where I am today. They don't cover the issues that a lot of women have. They don't give you back a sense of pride, a sense of yourself, self-esteem, your self-respect; they don't focus on those issues, and if those issues are not dealt with, then the issue of drug addiction is not going to be won. You have to give a person back their sense of value, because once you become addicted to drugs, you lose all sense of self, all sense of everything. There is nothing but the drug; that's all you are concerned with. It is an all-consuming hunger. And until you are properly educated, given the care, the time, the consideration that you need, individually, the problem won't be defeated, and it will not go away.

The Women and Children's Center gave me back my life. They gave my son a chance at life, and they gave my daughter her life back. Every day, she tells me how proud she is of me. She is involved in a peer educating program called Youth Educating Youth, where they help to educate other teenagers, and she tells me that she wanted to do this because of the work that I was doing and

the work that she has seen being done at the center. And I am very proud of her, and that gives me a good feeling, because a few years ago, she wouldn't have been there, and there is no telling where she would have been. She was very unhappy because she wasn't with her mother, which is where she rightfully should have been.

When she came to the center, there were a lot of problems going on in her life as well, due to my abuse. Through family therapy and counseling, we worked through a lot of those problems. She has done a lot of hard work. She has turned a lot of those problems from negative to positive. And I have learned how to be a mother again. That was something that for quite a few years was my least priority. Now, it is my utmost priority.

My son, I would say is a gift from God, but he is really a little terror. I am so thankful for him. He was a blessing. It is just such an incredible feeling to get up every day and to look at this little bundle of life and think that a few short years ago, if it weren't for the center, he wouldn't have had a chance; he may not have even survived.

I have gained so much for this program that I am currently involved in trying to enter a course so that I can become a certified counselor myself, because I know what the center has done for me, I know how they have influenced my life, and I would like the chance to give that back to someone else, because society definitely needs its family units, definitely, and I would like to do whatever I can to become an asset to society and to have my children do the same.

Thank you very much.

[The prepared statement of Ms. Higgins follows:]

PREPARED STATEMENT OF GAIL HIGGINS

Good morning Senator Dodd and members of the committee. My name is Gail Higgins. I am very proud and happy to be with you today to tell you my story.

Just 2 short years ago, my life was in ruins because of my heavy use of cocaine. I had given up custody of my 13-year-old daughter, Jamail, to my older sister. My bills went unpaid, my family relationships were a shambles and I had no self-esteem or respect. My life was a void.

When I learned that I had become pregnant, I was overwhelmed with a feeling of utter despair. How could I possibly care for an infant when I could not even care for my existing child? I could not bring a baby into the atmosphere in which I was living!

Because of my addiction, I failed to realize I was pregnant and did not seek prenatal care until my fifth month of pregnancy. While it was not easy, when I became aware of my pregnancy I stopped using cocaine on my own out of concern for my unborn child. I knew, however, that I would not be able to stay off drugs without help. The community health center referred me to the Women and Children's Center for help with my drug addiction. I was evaluated and found appropriate for treatment and placed on the waiting list. By that time, I was despondent about my life's situation.

It was not until my eighth month of pregnancy that a space became available for me at the Women and Children's Center. One month later, I gave birth to Edward, a normal, healthy boy. My life began to turn around.

The staff at the Center has helped me rebuild my life. They taught me to take responsibility and properly care for my baby. They made me feel, for the first time in many years, that my life had value. My daughter, Jamail, began visiting me at the Center and soon came there to live with me. We learned to build a healthy, honest relationship. Jamail's previous behavioral problems were brought under control. Jamail, Edward and I became a family.

After a 1-year stay, I successfully graduated from the program. For the past 7 months Jamail, Edward and I have been living together in our own apartment. Jamail is now 14 years old, happy to be reunited with me, and continues to make

progress in dealing with her own problems. Edward is happy, healthy and a developmentally normal 18 month old. My life has meaning, I have worth, I am valued. My parents are deceased, but my new relationship with my brothers and sisters is wonderful. They take pride in my achievements and we offer each other support and love.

My relationship has not ended with the Women and Children's Center. I return every week, often several times, to attend meetings and participate in special events.

I am continuing to grow. I have set goals for the future. I want to become a counselor and give something back by helping other women who are seeking to break their cycle of addiction and become responsible and loving parents.

I know that there are other treatment facilities that offer help to substance abusers, but virtually none could meet my special needs as a woman and as a mother. I would not have benefited from a program that did not recognize these needs and accommodate them. We need more programs like the Women and Children's Center. There are many people like myself out there who, if just given a chance, can make a good life for themselves and their families. Thank you.

Senator DODD. I'll tell you, I hope you stick with it, Gail.

Ms. HIGGINS. I am going to.

Senator DODD. You are great. I'll tell you that we are always proud of things that happen in our States. I know my colleagues will appreciate that we get baskets of fruit and other things from various States, as our colleagues are always trying to show us what their States produce. I wish I could take you, Gail, and send you around to 99 offices to show them what we produce in Connecticut, because I'd match you up with any basket of fruit anywhere. It was great testimony.

And Joanne, thank you so much for showing us part of the film. And I want to commend Hallmark. In Connecticut, we have a distribution center for Hallmark cards, so we'd like them to stay in the State, but they are a great company, and it might be worthwhile, even after Sunday, to talk about how that film might be made available in schools and so forth.

Ms. WOODWARD. I have talked to them about it, and I think they are very interested in the idea to do that.

Senator DODD. I think it could be very, very valuable.

One of the things, without revealing the plot, of course, that I found so worthwhile in the film is that it ends on a relatively high note, but there is a question mark in the end. This film doesn't end with every problem solved at all, really, but at least things seem to be pointed in the right direction. And I wondered how willing Hollywood is in a sense—and I guess people understand what I'm saying when I say that—to accept that sort of conclusion and whether they have that much say.

Ms. WOODWARD. Well, CBS was very kind. I think for a moment, we had a few problems about that, because I said this does not always have a happy ending, and to lead people to believe that it always does is wrong, and that the journey is what is important, and as long as the journey is in a positive way, as Gail found out, and you keep journeying, that is what is important, and that is what I wanted to leave them with—not that it was all going to be roses at the end of it.

Senator DODD. How long has the program been in existence now, Lisa?

Ms. DEMATTEIS. We opened in September 1991.

Senator DODD. So it is less than 2 years.

Ms. DEMATTEIS. Correct.

Senator DODD. And how many people have been in the program in total?

Ms. DEMATTEIS. Twenty-four total, eight of which are in residence now; eight that have graduated and are successful, remaining clean and sober; and out of the other eight who left before their time, half of those women are still clean and sober.

Senator DODD. And how are the ones who are there now doing?

Ms. DEMATTEIS. They are doing very well.

Senator DODD. The reason I mention that is because the reason I got so interested in this kind of program—and Joanne and I talked about this the other night—was because I tried to shop around to find out what were the best treatment programs, particularly for pregnant women and women with young children. I was stunned to find that there was one in all of New York City, Odyssey House, which I went to visit. It is, by the way, on the way to the jail; I mean, if you want to talk about settings that can send all the wrong messages. But there were something like 19 beds when I visited that facility. There may be more now in the city of New York, but I was stunned that in that city at that time, the total number of beds available to women with children who needed treatment for substance abuse was 19. And yet the success rate of that program was much higher than for parents in treatment without their children. Now, it is expensive; it is not cheap, and I want to get to cost in a second. But from a taxpayer's standpoint, if you want to invest money in something that works with women who are having children or who have children and are substance abusers, you should look at this. The court systems generally in the country, because there is this notion of abuse, where sometimes a strong case can be made, often move to separate, to take that child and put him in foster care or some other environment. And yet the effects are, almost with great predictability, that the likelihood of that woman who has lost her child successfully going through a treatment program just drops off the edge of the table; I mean, it just falls off—in part, because of the sense of failure and all the other problems we associate with it.

So again, it is not cheap to do it, but the success rates are great—and again, I don't know how it will end up and where you are going with all of this, but at least initially, it sounds like things are working pretty well.

Ms. DEMATTEIS. Residential treatment programs are so desperately needed. I believe that they are more important than outpatient clinics. Most people think outpatient is more cost-effective, but it is not. You can't expect that a woman can come in for 4 hours to get "warm fuzzies" and then go back to a dysfunctional setting; that 4 hours is just washed down the drain. That is not going to work.

We have got to approach this in a family environment. They need long-term care. There are so many issues that they need to work on, and you are absolutely right; we need more programs like this.

We have a woman who came in soon after Gail did, and her DCYS worker told me: "This woman will never stay clean and sober, and she will never regain custody of her two children, and we will probably take this child that she is carrying away from her." Well, I will tell you that she completed 1 year of treatment.

She is still clean and sober. She has just gained full-time employment, and she has gained full custody back of those two children and is doing remarkably well and is a wonderful mother.

Senator DODD. Terrific. That's great to hear. Tell me about the cost quickly and whom you choose. What are your criteria, other than facing the obvious ones, in making those decisions?

Ms. DEMATTEIS. It is a difficult one. Obviously, you have to be pregnant, and you have to be a substance abuser. What I do want to say is that when I started the program, I felt that the referrals would be 18-year-old women, 20-year-olds. They aren't. They are 25 to 35. They have at least two or three existing children, if not more. Due to the lack of programs, they have continued with their abuse, they have continued to have children. And many women have said that, "If there were a program like the Women and Children's Center years ago, I may not have had as many children as I have now—not that I don't love my children, but now I have so many care for." We have a woman who is 30, and she has eight children, and it is very difficult, because she is just learning the basic skills that she needs as a woman, let alone a mother.

As far as costs go, it definitely is more cost-effective to have these women come into residential treatment because of the success rate. Offhand, as to what are the exact cost figures, I really don't have those with me. When the women come in, it is very hard to determine shall we take this woman as opposed to that woman——

Senator DODD. Do they pay, in all instances?

Ms. DEMATTEIS. Title 19.

Senator DODD. How about people who have their own resources? Do you limit it to people by income levels?

Ms. DEMATTEIS. No, we do not, we do not.

Senator DODD. So if someone has the resources herself, she pays?

Ms. DEMATTEIS. Yes. And we have a sliding scale fee determined upon their income, and that's how we work that issue. The women are referred from just about every referral agency you can think of—physicians, DCYS, other treatment facilities. We do have women who enter treatment for 2 weeks to 30 days, because most treatment programs are 30 days—actually, that's not true; most programs are a week long, and if you are pregnant, most treatment facilities don't want to take you. If these women have been in treatment prior, sometimes they are referred because they need more structure, and a majority of them do.

Basically, with our waiting list, we take people as their number on the waiting list. Obviously, if a woman is homeless, she would have priority as opposed to someone who had a safe environment to live in. Unfortunately, most of these women do not have safe environments to live in; if they do have families, it is so dysfunctional they should not be there. And again, because of the grant for my program, you have to be pregnant. If you deliver your baby while you are on my waiting list, I have lost you, and you cannot come in. And unfortunately, when a lot of these women come in, they need treatment that minute. They feel like they are turned away; you know, the systems sets them up to fail, and this is a very big problem.

Senator DODD. How about the neighborhood? It is a residential setting.

Ms. DEMATTEIS. Yes.

Senator DODD. We have a similar program that was actually the basis of the COSA legislation out of Yale, and it is an outpatient program, more of a medical setting than a residential one. My colleague, Senator Coats, did a great job with us as we put that bill together, and this was a part of it. But I am curious as to how the program is received in neighborhoods, because of zoning and so forth; what was the reaction?

Ms. DEMATTEIS. It was a very long process. It took about a year and a half to 2 years to finally get this project off the ground and get acceptance in the neighborhood and the community. But I am pleased to tell you that we are very welcome in the community due to our successes. We have had a lot of positive press. The neighbors know who we are. Our children get to play with the neighbors next door. We aren't hidden in some back lot. The women feel like they have dignity, they feel like they belong in the neighborhood, and they are not hidden somewhere. I think that is so important.

Our program is not institution-like at all. If you were to drive down the street, it is a big, beautiful house; you wouldn't know that it houses this population. It is really wonderful, because the children who do live in residence—we have two 2-year-olds, we have a 12-year-old currently living there now—the 12-year-old goes to school, and she has friends nextdoor. Children sleep over at our house, and she sleeps over there.

We also provide a normal life for the child. We think that is very important. So that is why I think residential settings are so important for these types of programs.

Senator DODD. I agree with you.

Senator COATS. Thank you.

I appreciate the testimony of all three of you. Gail, thank you very much. I know it isn't easy, but it was eloquent and articulate testimony.

Ms. HIGGINS. Thank you.

Senator COATS. Joanne, in the film, one of the residents at the home said she had tried nine treatment centers, and Gail also indicated that if she hadn't gotten into this program, she didn't think it would have worked.

What is unique about this program that is different from the nine that were referenced in the film, or where Gail might have gone?

Ms. WOODWARD. Well, I think probably—and I'm sure that Gail and Lisa would both concur—so many of the programs that you go into a) don't want to take you if you are pregnant, because they are dealing with substance abuse, so it is two-forked—you are a pregnant substance abuser, you need help in both areas—and a lot of treatments are not set up to deal with both areas, which I think is the biggest problem.

Is that true, Lisa?

Ms. DEMATTEIS. Yes. And most of the programs are outpatient programs. As I said before, that is a major problem. Residential programs are needed, and long-term treatment is needed to end this problem, to end the generational cycle.

We see women come in whose mothers lived the same lives they are living. And I have seen as young as a 5-year-old child who was

sexually abused at that age, whose mother who was in residence was raped 35 times by her family members, and that resident's mother was also abused and hit that 5-year-old child. So something has to be done to stop this cycle. And that is why the Women and Children's Center is so unique, because we work on the entire family unit. You can't just deal with the woman who is in treatment; you have go to deal with her, her child, her children, and her family. And due to this comprehensive approach that we have, this is why our success is so high.

Senator COATS. I have a very close friend who several years ago was relating to me an experience that he had with his family. They discovered that their oldest son was a substance abuser, and he had the income that he could basically afford any treatment he wanted. So he scoured the country for treatment centers, and finally, everything pointed to one particular treatment center. So he called and asked if they would take his son, and the director said, "Yes, we will, but there is just one condition—we have to take the whole family."

And he said, "Well, I am a CEO; I can't do that," and the director said, "Well, then, we can't take your son, because we are in a sense dealing with a problem in terms of relationships and so on, and if we are going to successfully treat, we have to treat the whole group." I guess that is what you are saying.

Ms. DEMATTEIS. Yes.

Senator COATS. But let me ask you this question. Are most of the women who come to you single mothers, or are they part of a married family; and then, if they are part of that family, how do you deal with the husband, particularly if the husband is also an abuser, whether a substance abuser or a physical abuser?

Ms. DEMATTEIS. I would say that about half of the women are married and half are single. For those significant others, they may not necessarily be drug-addicted, but their mother may have been drug-addicted, so you can see the cycle is obviously why is he choosing a woman who is abusing alcohol or drugs. What we do is we tell the women that they are unable to go on passes, they are unable to do specific things unless they get their family in for therapy—and that works.

The family comes in, and we have a family therapist, and we provide couples therapy, family therapy, therapy with the children. We have also just recently started a group for the significant others, the male partners of these women, who have a lot of problems.

Senator COATS. That's done on an outpatient basis, though, right? The young mother is a resident, but all the other family members are counselled on an outpatient basis?

Ms. DEMATTEIS. They come to the center.

Senator COATS. Is that the extent of the involvement with the father?

Ms. DEMATTEIS. Absolutely not. We have significant others who are involved in Lamaz classes; they go to the hospital with the women when the babies are born, etc. So they are very much involved in the treatment of the mother and the birth of the child.

Senator COATS. What is the success rate of putting the family unit back together?

Ms. DEMATTEIS. I would feel comfortable with saying 50 percent. I feel comfortable saying that. We have had a lot of families who have engaged in therapy, and we have seen major changes go on with the family, not only during treatment, but when the family leaves; they are continuing to take care of themselves as a family unit, and they continue with therapy, and we refer them to outside therapists, etc. We also provide them with accessibility to staff at the center, and that is really helpful.

You can't just have a woman come in for a year and say goodbye to her, and you can't do that to the family, because the relationships that they establish are so strong and so connected that they need to continue doing that, or else this is not going to work, the treatment.

Senator COATS. I appreciate the testimony. It is obviously an impressive program. I guess what concerns me is what concerns all of us, and that is when we find a model like this, we usually find that it is one that is very intensely involved, and obviously takes a lot of resources, and then when we weigh the resources available against the enormity of the problem across the country, we wonder how we are going to get from here to there, how we can establish enough of these to break the chain and to truly make a difference.

Ms. WOODWARD. Could I just add something, though, to that point, and something that we also say in the film. That is, it is certainly an expensive endeavor to do something like this, but it is going to 10 times more expensive to deal with these children when they grow up and are totally dysfunctional, a good many of them, and then become dysfunctional, and there are jail sentences. So that it is a question of apples and pears, I'm afraid—and I know how difficult it is, but it does seem to me that we can't forget that element. It is always going to be money, and we are going to be paying for it down the line. It's good if we can pay for it in a positive way which might stop this.

Senator COATS. Thank you.

Thank you, Mr. Chairman.

Senator DODD. Senator Kassebaum.

Senator KASSEBAUM. Just briefly, Gail, I would also like to say that your testimony was exceptionally thoughtful, and I'll put in a plug as well for the film. It is an important film to see. It is not only moving, but it is a very important message.

One thing that was touched on in the film, and I think, Lisa, you referred to it, and I'd like to ask a bit about is the fact that in all too many cases, a mother would have to choose between putting her children in a child protective service system in order to get treatment. And many times, I'm sure they will just say, "I'll go ahead and continuing abusing and keep my child." Is this one of the problems? It was touched on in the movie when you said because of who Phoebe's mother was, being a congresswoman, she probably wouldn't have to face that choice, and there would be an exception made. Is that right?

Ms. WOODWARD. Yes.

Senator KASSEBAUM. Well, I don't know how it is in Connecticut, but I think many times, if you are going to put yourself into an abuse treatment program, you have to put your child under the child protective service system; is that right?

Ms. WOODWARD. It's automatic.

Ms. DEMATTEIS. Yes, it is automatic.

Senator KASSEBAUM. So isn't this a problem? That's what I'm asking.

Ms. DEMATTEIS. It is a problem. The women who come in—and again, because we are only licensed for eight women and seven children, we have women who can't bring their children with them immediately, so they have to contact DCYS. And the agency is very supportive, and they bring the child there to visit the mother.

For example, women who come in who have their children already in protective services have visitation, and the visitation increases throughout her stay, and it builds up to the child staying over, and then eventually the child coming and living with the mother, and there is reunification, which is really wonderful.

But we are mandated by the State that we have to contact DCYS if we suspect child abuse while the mother is in treatment with her child. I am happy to tell you that that has not happened in the 2 years that we will have been open this year. That has not gone on at all. The women are learning parenting skills; they have a parenting group every day. They also go to parenting groups outside the agency, and that is a very big component of our program.

Senator KASSEBAUM. So you have been very encouraged by the child protective services in Connecticut to do this type of program.

Ms. DEMATTEIS. Yes.

Senator KASSEBAUM. Is there encouragement from them to start other centers?

Ms. DEMATTEIS. Well, for example, as DCYS is now funding us, and in the beginning they did not, and because of the wonderful work that we are doing, and they were so pleased, they are funding us now. And we have just been recently been awarded a new grant from the Connecticut Alcohol and Drug Association—I am very thrilled to tell you this today—and I will also be opening another residential treatment facility in Groton, CT, which is scheduled to open in January 1994, as well as an outpatient clinic, which should have been open 2 months ago, but I am working on getting that going. And DCYS has been very supportive. The commissioner met with me last week and said, "We are very interested in funding this programs and want to see more of these programs come up, because the work that you are doing is so incredible."

As I shared before, there are many DCYS workers who have said, "This woman will never get her child back; she will never care for this child"—that is not true. When given a chance, these women rise to the occasion. They want to be good mothers. They have never been given the chance, and what they do with their children, the bonding process—most of them breast feed, most of them go to LaMaz classes—to see that interaction is one of the most wonderful experiences as a director that I see go on there.

Senator KASSEBAUM. Was yours the first program in Connecticut like this?

Ms. DEMATTEIS. No, it was not. It was the second.

Senator KASSEBAUM. But still, that is really extraordinary, and you have just been open 2 years.

Ms. DEMATTEIS. That's correct.

Senator KASSEBAUM. I think every State is finding that there has just not been this kind of emphasis, and they are slowly gaining awareness of the importance of having it as a unit.

Ms. DEMATTEIS. And the program is very structured, but we also have fun there. It is very loving. If any of you were to come—and I know that Joanne Woodward would testify to this—it is just such a special place. There is unconditional love there, there is structure, there are rules, and there are certain things that you must adhere to—but we have fun.

My staff is a wonderful staff of women. We work very closely with the residents. It is the most unique setting. I am very proud to have started this program and to see what goes on there. It is very remarkable. And more programs are so much needed.

Senator KASSEBAUM. In the film, there is no nonsense about the rules——

Ms. DEMATTEIS. Yes, that's right. [Laughter.]

Senator KASSEBAUM. —and it seemed to me that was an important guideline.

Ms. DEMATTEIS. Gail, you may want to say something about the rules and what they were like for you when you were in treatment there.

Ms. HIGGINS. At first, it was hard to adhere to the rules because after so many years of not conforming to anything, it was like—hey, I'm grown, and I don't need you to tell me anything—and then on the other hand, well, if you're so smart, what are you doing here in the first place?

The rules are necessary. They are necessary, and after a while, they are not hard to abide by. The rules are rules you have to have to run a household, and if you are going to be a mother and have children, you need structure, there are certain things that you have to do and certain times that they have to be done. And these are skills that almost every woman who has been a substance abuser needs to relearn. So they are very necessary, but they are also very beneficial.

Ms. DEMATTEIS. And also, what is very unique about the treatment program is that it is geared for women and children. Traditional treatment facilities for women don't work because they are geared for men, and it is unrealistic to think that you can place a woman with these issues in treatment with a male, because the majority of these women do not know how to communicate with a male—they have been in abusive relationships, and treatment does not work. So that is another facet of our program that is so wonderful, because it is geared toward women.

Senator KASSEBAUM. It certainly is impressive. Thank you very much.

Ms. DEMATTEIS. Thank you.

Senator DODD. I would say DCYS is our Department of Children and Youth Services. I know each State has a different name for those things.

Senator KASSEBAUM. Well, no—I finally figured it out.

Senator DODD. Senator Kassebaum has a good Connecticut staffer here from Kansas.

Well, this has been tremendous testimony. There is just one point I wanted to make, and you sort of anticipated the question,

Lisa, and that is as to the role of men in all of this and the courts. One of the things we did under the COSA bill was to encourage education and training. We wanted to encourage our court structures, the judicial structure, to have better education about parental substance abuse, so that when they are faced with making judicial decisions, there will be a heightened degree of sensitivity and awareness about what will work in some of these cases. And obviously, all we can really do is recommend in this area; we can't mandate. But we are trying to provide a little funding to get the entire court structure, judicial structure, to become more aware of these kinds of options so that as they deal with making decisions about children and families, they are aware of alternatives to just pulling a child away or sending someone off to a penal environment, if you will, given the failure of that approach.

One of the things that I was impressed with, and I've got to go back and check on this, about the Odyssey House program was that there were men involved—not necessarily living there with their children, but participating in drug treatment and working with the children to learn parenting skills. The courts were saying if you will enter this kind of a program, we can work something out that's a little different than what would be the normal case in terms of your time served. And I remember talking with some of these younger men, and it was moving—I mean, they were doing feedings and getting involved in the basic health requirements of these children. These were young men who had been fathers or were fathers, and it was pretty remarkable to watch this metamorphosis of some of these tough kids all of a sudden learning that they could be successful at this. I think a lot of the problem is just assuming a total lack of success, or ignorance about it. But anyway, it's an aspect that I think is an important element.

I do forums at the high schools in my State—I have spoken, I think, at every public high school in the State, to the juniors and seniors, over the last 10 years—and one of the best forums I ever had was in New Haven at Wilbur Cross High School, where the topic was child support. And all I did was monitor a debate for an hour and a half between the young women and young men. And I'm not that old, but the idea that this would have happened in my time in school—yet it went on, and it was phenomenal, this debate and discussion about responsibilities and support and so forth that happened between these kids.

I think more needs to be done with the men, and somehow they need to be integrated and involved more. And I understand you are obviously doing it, in your response to some of Senator Coats' questions, and I realize it is taking on an awful lot, and it is difficult—but to the extent we can, I think it is really worthwhile in the long-term.

That's really more of a comment than a question. At any rate, I thank all of you for being here.

Joanne, we really look forward to this program at 9 p.m. on Sunday night, May 2.

And again, Gail, I want to underscore that we need to get you out more—not only do we want you involved in the program, but we up here listen to a lot of testimony, we listen to a lot of witnesses, and what Senator Kassebaum said was not a gratuitous

comment; we aren't just trying to be nice to you in what Senator Coats said and what I am saying to you. You are a very articulate witness. You are a very important spokesperson. And with all due respect to the rest of us who care about these things, you have been through it; you offer incredible opportunities as a witness to what can happen and what can be done. And I would strongly urge you in addition to your involvement and work with the program to think about ways in which you would be willing to find public forums to talk about it. That is a God-given asset you have, and it should not be lost. Those were not just kind comments that were made to you by the Senators up here. We listen to a lot of people, and you are very, very good at explaining something. So we want you to get out there.

Ms. HIGGINS. Thank you.

Senator DODD. And we don't want you picking up on this movie and running for the Senate; we want you to stick to what you are doing. [Laughter.]

So we thank you all very, very much.

Ms. WOODWARD. Thank you, Senator. We appreciate it very much.

Ms. DEMATTEIS. Thank you very much.

Senator DODD. Before introducing our third panel, let me just note that we have a vote that will be occurring here shortly, so I am going to first of all introduce you very quickly. Panel 3 includes Judy Langford Carter, executive director of the Family Resource Coalition, a national clearinghouse for family support organizations. I know that you have been involved, Judy, with prevention for a long time, having directed Illinois' Ounce of Prevention Program before coming to the Family Resource Coalition. Your expertise is welcome as you share what supportive public policy efforts need to be promoted.

Margaret Williams, our next witness, runs a program that is a shining example of a family resource and support program, Friends of the Family. And Margaret, I understand that your program was honored by the Ford Foundation and Harvard as one of the best examples of a government-run program in the entire country. We are going to hear about this program, which was the principal model, I might add, for the 1990 family resource legislation.

And Shurnice Mackey is one of Maryland's many success stories. We thank you for coming, Shurnice, and being willing to talk about your own personal experiences and how the program has helped you get back on your feet as well.

And Judy Moler, I will actually ask Senator Kassebaum if she'd like to introduce you, because I know the Senator knows Judy and is familiar with the program.

Senator KASSEBAUM. Thank you. I am just really pleased to have Kansas represented here, because I do believe, particularly in the past several years, there have been some very important initiatives taken, and we have some wonderful programs. Judy Moler is director of Local Initiatives for the Corporation for Change, which was set up by the Kansas legislature to serve as a conduit for a number of programs taking place around Kansas. And I think, Mr. Chairman, that many of us on this committee share the desire to encourage as much coordination and cooperation among programs and to

provide that type of outlet. I think it is going to continue to provide a very important venue for understanding the comprehensiveness of a system which has to work together to really be effective.

Senator DODD. We are certainly glad to have you here.

I am going to make a recommendation to my colleague. We are going to vote at noon. I would ask Judy if we could open with her; I'll run over and vote, and come right back. That way, you can be here to hear Judy's testimony, and we can switch positions at that point, if that's all right.

Senator KASSEBAUM. That's fine.

Senator DODD. And let me also express for Senator Mikulski her regrets. She is chairing a hearing of the Subcommittee on Aging this morning, and the conflict just made it impossible for her to be here in her capacity as chairperson of that subcommittee; but she wanted to apologize to you, Margaret and Shurnice, for not being able to be here to introduce you to the committee. But we thank you for being here.

Judy, we'll begin with you; I'll scurry over and vote and come back in 5 minutes.

STATEMENTS OF JUDY MOLER, DIRECTOR OF LOCAL INITIATIVES, CORPORATION FOR CHANGE, TOPEKA, KS; JUDY LANGFORD CARTER, EXECUTIVE DIRECTOR, FAMILY RESOURCE COALITION, CHICAGO, IL; MARGARET WILLIAMS, EXECUTIVE DIRECTOR, FRIENDS OF THE FAMILY, BALTIMORE, MD, AND SHURNICE MACKEY, BALTIMORE, MD

Ms. MOLER. Chairman Dodd and Senator Kassebaum, I am happy to be here. My written testimony talks about some demographics and lowering trends which are startling for what is happening to children and families across the United States, and we particularly paid attention to it in Kansas, and I am here to tout our program. I won't go through those demographics since time is short, but I would like to tell you some of the solutions we came up with.

In 1991, a committee of the Senate and of the House got together and brought in as their partners business, consumers, and advocates at the table, and looked at children's issues in Kansas. Before that time, I think committees pretty much looked at isolated areas—they looked at funding, they looked at social programs, but never the two together, and always kind of segregated areas as to how they went.

After about 9 months of hearings with the consumer advocates and business people at the table, they came up with what we call the "Kansas Blueprint," and that blueprint is back there for any of you who are interested in it. It is our "bible," as I call it, and within it are the seven targets for change. Those targets are: to give greater support to families, which we have heard about today; to invest in young children, zero through 5; to restructure schools; to improve the physical and mental health of children and families; to make business a partner; to reduce high-risk behavior, and to modify the service delivery system.

Also out of that initiative came the Corporation for Change, which Senator Kassebaum referenced. The Corporation for Change is unique in that it is a private and a public entity. We receive

money from the Annie E. Casey Foundation, and we also receive State money, to look at the way services are currently delivered to children and families and to make recommendations both at the State level and to the Federal level about barriers and the things we see that are going well for children and things that aren't going so well, and to try to correct those.

My job is director of Local Initiatives, and in really the year since the corporation has been in effect, we have had 26 councils spring up like mushrooms, as our speaker of the house says, across the Kansas prairie. As you know, mushrooms each look pretty individual, and our "mushrooms" of councils look pretty individual, too.

But the important thing about those councils is that they bring all the players to the table in a fabric. They bring the home visiting entities, and in Kansas we have several home visiting entities—we have Healthy Start, we have Parents as Teachers, we have Head Start—we bring all of those people together, and they bring the drug and alcohol people, they bring the Family Resource Council programs together as they plan for their local communities. We like to think that we have given them a lot of autonomy as they plan.

The kind of proverb that guided the Senate and House committee as they met was: "It takes a whole village to raise a child." That is why we have come up with the local community councils.

When I was a little girl growing up in Yukon, OK—which is now famous because of Garth Brooks, but then was just a sleepy little Oklahoma town—I backed out of the grocery store when I was about 16 years old in my dad's big Oldsmobile and ran into somebody. By the time I got home, about three blocks away, my dad knew. I think that's the kind of overall "village" caring that we talk about, not just being a tattle-tale, but that somebody cared that I had been in a wreck and called my dad—that's what we're talking about when we say it takes a whole village to raise a child. That child belongs to everyone in the village.

I am going to tell you real quickly about three of our councils. In Saline County, in the center of the State, they have started a homeless coalition in partnership with the local university and with the consumers and with housing advocates, and broadened those who are signing the song of getting transitional housing for families and for children. In Kansas, which you think of as the breadbasket of the world, we currently have about 4,600 homeless children of school age. That's just the tip of the iceberg, because we aren't talking about children who aren't counted because they are zero to 5, or not in school.

In Osawatomie, KS, in northeast Kansas, a "village" of about 3,000, they started a citywide campaign where they recycle cans for kids and have scholarship programs, buying Boy Scout uniforms, or swimming lessons, piano lessons, things that are traditionally not funded by anybody. They have opened a health care clinic for uninsured and underinsured two nights a week through these volunteer efforts in the local senior citizen facility, and it is staffed by volunteer doctors, social workers and nurses.

And in Sumner County, KS, where the local council is headed by a judge, they came up with a program for sick child care, in a collaborative effort between the hospital and the local education group. That sick child care takes children who are too sick to go

to school or to child care, but they don't need mom and dad at home; they aren't that sick. So it works out well to support these families, and yet the children are adequately cared for.

We in Kansas and I think here at the Federal level want to empower local communities by shifting responsibilities and getting resources to local entities; but as we do that, we at the Federal and State levels need to be responsive by making those resources flexible and to give information to localities, such as the kids' count information, that tells the demographics of what is going on in their village.

We all need to be conscious of outcomes and accountability—I am really made conscious of that because my husband thinks I go to meetings and teach people to sing "We are the World," and as a good Chamber of Commerce member, I need to tell the story to him that tells what the outcomes are for these kids. It is no longer helpful to just measure the number of children served for the sake of serving children. We need to measure the quantitative results in the life of that child.

As councils identify barriers, we need to be their partners at the State and local levels, the linkage to help them overcome those barriers. We applaud in Kansas such efforts as the Young Americans Act, which talks specifically about coordination in serving children and youth and families, and provides incentives to States and communities to do this. And, after our experience at the local level, the only thing we would add is: Bring everybody to the table. Bring business, bring consumers, bring advocates, because the more we teach others to sing our song, the stronger our song will be.

Thank you.

Senator Kassebaum [presiding]. Thank you very much.

Obviously, I am a bit parochial in saying we are very proud of this initiative in Kansas. But I think it is indicative of what a number of States are doing, utilizing the initiative and flexibility, and being willing to take some risks, to fit what a particular area needs. Baltimore will be very, very different from Osawatomie, KS. So I think that what the hearing has indicated this morning is some of the tremendous work that is being done around the country—it is small. We often wish that we could clone, as has been said before, some of these efforts and see them spring fully into bloom elsewhere. But I think the fact that they are now being undertaken and recognized is a tribute to all involved.

Ms. MOLER. Thank you.

[The prepared statement of Ms. Moler follows:]

PREPARED STATEMENT OF JUDITH ANDERSON MOLER

American society has undergone profound economic and demographic transformations in the last 30 years. The family and social and educational institutions that prepare children to become capable and responsible adults have not been able to keep pace with this change.

We in Kansas believe that families and the circumstances of family life will remain the most critical factor in determining how children develop. At a time when the family is undergoing extraordinary social, demographic, and economic change and instability, society must ask what it can do to strengthen families and support the healthy development of our children.

We in Kansas believe that we need to have a comprehensive, coordinated strategy in place for an investment in children. The long-term benefits outweigh the short-term costs. Such a strategy must redefine education as a process that begins at birth and encompasses all aspects of children's early development, including phys-

ical, social, emotional, and cognitive growth. We view early childhood development, education, social services, job training, and economic development as parts of an interdependent system of human investments which must be addressed together, rather than independently or piecemeal.

Some of the trends which compelled Kansas to act quickly are:

—Population trends impact the work force of tomorrow. The number of children in Kansas has declined slightly, but the number of older Kansans continues to increase.

—More children are living in poverty, particularly children of color.

One in every seven Kansas children lives in a family without a minimally decent income.

—Changes in the family create more demand for social supports.

Today, only three out of 10 families fit the "traditional" pattern of a homemaker mother and bread winner father.

—Global competition demands skilled workers and educational excellence. Even though the level of education in this country has been steadily increasing since the 1950's, still.

One-fourth of our Kansas public school students are at risk of school failure.

—Prevention is not a priority. Prenatal care has yielded more than $3.38 in savings for every dollar invested, yet in Kansas:

Only 85.7 percent of mothers received adequate prenatal care.

Early immunization for a variety of childhood diseases saves $10 in future medical costs for every dollar invested, yet, 48.7 percent of children under two have not been fully immunized.

—Kansas puts too many children in institutions.

Children in Kansas Social and Rehabilitation Services (SRS) custody have increased 28 percent since 1985.

Since 1980, the number of Black children in SRS custody has increased 74 percent, the number of Hispanic children is 88 percent.

Kansas ranks seventh highest in the United States in rates of juvenile incarcerations.

—High risk behaviors are increasing, and expensive.

Each year, spending in Kansas has been pegged at $345 million per year.

In Sedgwick County, KS, alone, there are over 1,200 gang members, many affiliated with other gangs across the country.

The response to these demographics was Kansas policy makers' development of the Kansas Blueprint, the identification of the 7 Targets For Change and The Corporation for Change, a public/private partnership charged with implementation of the Blueprint.

I. Greater support to children and their families. Any program to help children must also help strengthen the entire family. However, when parents cannot nurture their children, the State and local communities must provide assistance an equally nurturing alternate environment. Parents need additional support at the birth of a child, or during a divorce. The changing structure of families requires a greater degree of support to keep them healthy and functional than in the past. Working parents must have access to affordable child care; work environments should accommodate family responsibilities to the greatest extent possible. Every child should have adequate food, shelter, clothing, health care and a nurturing environment.

II. Invest in young children, ages 0–5. Our investment priority should be on programs which impact the physical, social, emotional and cognitive development of young children. We must prepare children better so that they enter school ready to learn. We must train parents to be their child's first and most important teacher. Prevention, early identification and intervention into educational, social and health problems is the most cost effective way to deal with problems. We must prevent children from being abused/neglected and demand that systems respond when abuse and neglect are reported.

III. Restructure schools to respond to changing educational developmental needs of children. Public schools should work to ensure that early childhood programs are available to children who need them. They should have appropriate goals which can be used as performance indicators for the public to measure effectiveness. Kansans should develop an agreement as to what they expect of schools and provide appropriate resources. Schools should be restructured to increase educational performance of children and service as a point of access for community services.

IV. Improve the physical health and mental health status of children. Every Kansas child needs access to affordable primary health care. Preventive health care should be given priority. Children with handicapping conditions should be served in

the home or community whenever possible. Outreach strategies must be devised coordinated with social service delivery systems.

V. Modify service delivery systems. Programs for children and families must be flexible in design, administration and funding, and should allow service providers to package an appropriate array of services for a child, free from some of the constraints imposed by institutionalization of children, or removal from families, and explore alternatives.

VI. Make business a partner. Businesses should play a leadership role at both the State and local level in identifying strategies, determining needed resources, giving incentives to students to learn, encouraging its employees to volunteer, and also by examining its own policies, practices and activities in supporting employees in their family roles. Businesses should work with educators to develop a challenging curriculum and greater incentives for students to learn better.

VII. Reduce high risk behavior in children and their families. Programs to reduce the incidence of teen pregnancy, teen suicide, substance abuse and juvenile crime should be implemented, particularly in communities with a high incidence of drug abuse, suicides, gang activity or births to unmarried minors. We can break the cycle of at-risk behavior for families through programs designed to help teen parents learn job skills and programs to strengthen the ability of teenage parents to guide, direct, and nurture their children.

As part of the Kansas plan to strengthen and empower our communities we have developed local planning councils to address locally the 7 Targets For Change as well as identifying local needs, defining appropriate responses and allocating resources.

In one year's time, there are 26 community planning councils across Kansas. As Speaker of the House Robert H. Miller said, "they're springing up like mushrooms in the rainy Kansas springtime." Like mushrooms, they are each very different.

I'd like to tell you about these planning councils in Kansas.

The Saline County, KS, Planning Council has formed a coalition around homelessness and transitional housing. In a partnership of business, housing advocates, consumers and local university personnel developed a community-wide plan addressing community transitional housing.

In Osawatomie, KS, a town with a population of 3,000, a city-wide effort by the local planning council has resulted in a health care clinic for uninsured and underinsured persons in the community. The local Senior Center allows their facility to be used two evenings a week to house the clinic.

In Sumner County, KS, the local council has developed a sick child care program in collaboration with the local school district and hospital. Children who are too sick to go to school or day care go to a special program housed at the hospital. This supports the family by allowing parents to work while their children are adequately cared for at the hospital.

We want to empower local communities by shifting responsibilities and resources to local entities. in return, Federal and State Government need to be responsive with flexible dollars and information such as KIDS COUNT. All levels need to be conscious of outcomes and accountability. It's no longer helpful to measure the number of children served for the sake of serving children. We need to measure the quantitive result in the life of the child.

As local councils identify barriers to a comprehensive system, we need the State and Federal linkages in order to be partners in problem solving.

We in Kansas applaud Federal legislation such as the Young American Act which works to improve coordination of programs serving children, youth and families, and provides incentives to State and community programs to do this. After our expansion at the local level, we urge you to include all the partners in decision making—government, business, advocates, and consumers. The adding of those voices can only make our song stronger. I welcome this opportunity to speak to you today. I would answer any questions you might have.

Senator KASSEBAUM. Judy Langford Carter.

Ms. CARTER. Thank you. I do represent the Family Resource Coalition, which is the national organization of thousands of family resource programs in all 50 States around the country, and I will talk a little bit about the national scene, and then Margaret Williams will talk about a State network.

Three years ago, there was Federal legislation originally authorized at $30 million to support State networks of family resource and support programs in local communities. At that time 3 years

ago, we estimated that there were maybe six or eight States who were in a position to apply for that money in supporting the networks of programs that they had.

Last year, we finally got a little bit of money, and $5 million was appropriated for the grants; and this year, we anticipate that three States will be awarded about $1.5 million each to expand and support programs in their communities. If our phone calls at the National Resource Center for Family Support Programs are any indication, more than 35 States will apply for these funds to support exactly the kinds of programs that Judy Moler is talking about, to give the flexibility to local programs and to give a State network the opportunity to facilitate and enhance that.

The explosion of interest in the last 3 years in these kinds of programs and efforts all around the country represents the growing understanding of many States and many other institutions that these flexible, local, family-oriented programs offer two very important things. They offer an opportunity to make all of the other services more effective by pulling those pieces together and not duplicating them, but it also offers a way to start a prevention agenda that is not specifically tied to one particular funding stream or one particular kind of effort.

Family resource programs include in many communities the resource mothers programs that the first panel talked about. Family resource programs pick up where residential treatment centers leave off. They offer a number of places in every community for parents to get whatever kind of support they need. And they also offer a bridge from wherever those families are into the more intensive kinds of services that they need.

We think that it is time to fully support the grants program, to fully fund it and expand the States' capacity to support and link and facilitate and expand those programs.

One of the characteristics of family support programs around the country is that they are there for all parents, not just for people who are labelled as deficient or at-risk or are there for some particular kind of problem. And I think all of us know that every parent who has ever survived parenthood in any form could never claim to have done it all by themselves; and all of us have used and needed and worked with a whole network of friends and neighbors and relatives and professionals who helped us figure out how to do that.

About 15 years ago, family support programs started to spring up spontaneously around the country, not because some service provider or some government program said this was a good thing to do, but because parents were beginning to say these support systems are not there in the same ways they once were, and we really need more support and different ways to do that.

And I think we would all say that the challenges for parents today are greater than at any time before in our history. The National Commission on Children in its final report, as one way of supporting the healthy development of children, recommended that the first-year Federal investment in these local family supportive outposts around the country should be $370 million, and expand over 5 years to a total of $1 billion of Federal money and match money from local and State sources of another $1 billion. That is

the kind of support system that is envisioned as a way to have healthy development for children.

I would like to talk about two specific examples of the way States are utilizing local family support programs as a way to change the systems that they have.

Senator KASSEBAUM. Judy, pardon me just one moment. Perhaps before you mention those two specifics, I should temporarily recess the hearing because I may be late getting over to the floor to vote; I only have about 5 more minutes to go. So I am sorry, and I hate to interrupt, but I think Senator Dodd will be back in just a few moments. Thank you very much.

[Recess.]

Senator DODD. The subcommittee will come back to order, and my apologies for the minor interruption.

We are in the middle of your testimony, Ms. Carter. Sorry to interrupt you.

Ms. CARTER. That's all right because then I get to say what I didn't say at the beginning, which is how much we appreciate your leadership on this program.

Senator DODD. Thank you. You are kind to say that.

Ms. CARTER. We really do, and this is one of those areas where we have seen tremendous growth in the interest in the Family Resource and Support Grants Program. It really is because of your leadership that it is there, and we count on that as we move forward from here.

Senator DODD. Are you going to move to Connecticut any time soon?

Ms. CARTER. We have a lot of programs in Connecticut. As a matter of fact, the chair of the steering committee of the African American caucus of the coalition is from Connecticut, Mustafa Abdul Salam, who runs the New Haven program——

Senator DODD. Oh, yes. I know him.

Ms. CARTER. Mustafa is currently going onto the Family Resource Coalition board officially in June.

Senator DODD. Yes. I deal with him a lot down at the Science Park on issues involved there. It's a small State, so we all know each other.

Ms. CARTER. One of the things that I wanted to talk about today is to give two examples of the ways that States are utilizing family resource and support programs as a part of other systems reform. These are by no means the only examples, but they are some of the most dramatic ones, I think, about what is going on right now.

In Kentucky, about 3 years ago, that State had an opportunity to completely redesign their educational system. One of the most significant parts of that was adding on as a part of education reform family resource centers in all schools where more than 20 percent of the children were eligible for reduced-price lunch. The rationale for including that as part of education reform was the explicit acknowledgment that even the most perfect educational system was not going to be able to produce the kinds of outcomes that they wanted unless it had strong partnerships with parents and with other resources in the community.

Those Kentucky centers were modelled after the family resource centers in Connecticut and the youth services centers in New Jersey.

Another example is currently, with funding from the Pugh Charitable Trust Children's Initiative, there are five States currently in the planning process—the States are Rhode Island, Minnesota, Florida, Georgia and Kentucky, and they are engaged in planning a complete revamping of all their services for children and families into an integrated program that will feature as its hub local, universally accessible family centers as the hub for all the service systems as well as the hub for prevention, to promote healthy development of children and healthy functioning of families.

Family support in many ways is not a service in the traditional sense of the word. It is an approach to working with families that starts with encouraging and engaging parents and building their own capacity to work effectively as a family.

A family resource program doesn't necessary provide everything a family might need, but it does have very strong linkages with the other resources that are in that local community. There are very effective mechanisms at the neighborhood level for helping families make sense of the fragmented categorical services that families who need help from public services often face. Family resource programs believe that you are supposed to do whatever it takes to help a family get where they want to go, and as a result, family support staff everywhere spend a lot of time as service integrators, helping families navigate the maze of entitlements and appointments and case managers who may or may not be helping them very effectively.

Staff also serve in many cases as a bridge between parents and more intensive services that they may need. For example, it may take a parent several weeks of coming to a prevention-focused family resource program to gain the courage and the trust in the staff to admit that they have a substance abuse problem and ask for help. Once that problem is identified, family resource staff work as an advocate with those families to help families get the services they need outside the program and also continue their relationship with that family within the program.

At the National Resource Center for Family Support Programs which is operated out of my office in Chicago with some Federal and mostly foundation funds, we receive hundreds of calls monthly, increasingly calls from public agencies, from State governments, from school systems, who are trying to accomplish both the preventive functions that a family resource program provides and the service integration piece that the family resource program can also provide at the local level.

We see this phenomenal outpouring of interest that is overwhelming our capacity to deal with it as a signal for the vast need of those kinds of mechanisms at the local level that are directly responsive to children and families. We believe that the Family Resource and Support Grants Program is one vehicle to create those mechanisms at the local level and to support States' capacity to facilitate that and enhance it. We think that is a critical part in the development now of an effective service system that really does serve families effectively and provides some of the preventive serv-

ices that we need to have. And we need the Federal help in beginning to do that. There is a lot of State support. I met just yesterday with a number of people form several States who are interested in forming their own State council of States that are working with family resource and support programs, as a way to share resources and to share information about that.

So this idea has really caught on in a big way, and what we need is some more Federal leadership and some more Federal resources to help support and facilitate that.

Thank you.

Senator DODD. Thank you.

[The prepared statement of Ms. Carter follows:]

PREPARED STATEMENT OF JUDY LANGFORD CARTER

As the representative of the Family Resource Coalition, a multi-racial, multi-disciplinary grass roots movement which has been struggling for recognition for more than 10 years, I am very pleased to be here. As our organization acknowledged at our national conference last May with a special honor for Senator Dodd, we appreciate the leadership for our programs and ideas that he has provided, and thank him on behalf of the Family Resource Coalition membership for his support of the National Resource Center and the family resource and support grants program. We believe that the time has come for a new national commitment to supporting families, who on a daily basis, without much help from anyone, are doing the most important job in America: that is, raising our net generation of learners, workers, and citizens.

At this very moment, in family resource programs across the country, parents of all kinds are participating in activities designed to help them be better parents: child development classes and messy activities for parents and children, help in seeking access to health or education or substance abuse services for themselves or their children, help in working with their child's school or addressing a community problem, encouragement to form and use their own parent support groups, even; job training and vocational services.

Parents may be meeting in a community center, a school, a storefront, a health clinic; or they may be working with a home visitor in their own homes or speaking with a volunteer helper on a warmline. Wherever they are, and for whatever particular reason they came to the program, every parent gets a warm welcome, a pat on the back (or a hug), and an enormous dose of loving care from staff who have been carefully trained to do "whatever it takes" to encourage and support the parents who walk through their doors.

Family resource programs are there for all parents, not just for parents who are identified as "at risk" or labelled as otherwise deficient. We know that every single parent who has ever survived parenthood has used some sort of support system outside their immediate family, whether it was a network of friends and neighbors, advice and care from grandmothers and aunts, participation in churches or sports teams or scouts, or professional help from teachers or doctors or others we consulted as our children grew. It is a fact of American life at this point in history that these support systems are less available to families than they used to be in every kind of community, and that the challenges of growing up for all parents and children, in every community, are greater than ever. Seeking help in the difficult job of parenting is a sign of strength and intelligence, not a signal of weakness or failure. Family resource programs go to great lengths to establish themselves as a non-stigmatizing, welcoming place to be, so that parents will be more likely to take advantage of what it offers.

Besides serving as a focal point for family capacity-building (and therefore, prevention of a variety of problems related to the inability of families to adequately support their children's healthy development), family support programs are also effective neighborhood mechanisms for making sense of the fragmented, categorical system of services families who need help from public services often face. In doing "whatever it takes" to help the families who walk through their doors, family support staff often spend time as service integrators, helping families navigate the maze of entitlements and appointments and case managers that may or may not be effectively helping them.

While family support is not a "service" in the traditional sense of the word, it is an approach to working with families that starts with encouraging and engaging

parents, building their capacity to work effectively as a family. While a family resource program may not provide everything a family needs through its own program, it does have strong linkages with all the other services in the community that its families may need. Staff in the family resource program often serve as a bridge between parents and more intensive services they may need; it may take a parent several weeks of coming to a program to gain the courage, and the trust in the staff, to admit that there is a substance abuse problem in her family and ask for help. Once a problem is identified, staff work as a trusted advocate with the parent to get the right services outside the program and to continue the relationship with the family within the program.

FAMILY RESOURCE PROGRAMS AND SYSTEMS CHANGE

While family resource and support programs have most often been spontaneously started in local communities by a variety of private agencies, many State governments, school systems, and local governments have begun to look to these family focused programs as essential partners both in an effective prevention agenda and in efforts to integrate fragmented services more effectively for families. Let me give you a few examples.

In Kentucky, one of the most promising aspects of its unique, "world class" educational reform is a statewide initiative to develop a family resource or youth services center in every school with a high proportion of poor children. The rationale for the centers was an explicit acknowledgment that even a world class educational system could not produce world class outcomes without real partnerships with families and other community resources that children need for healthy development. The Kentucky centers were modeled after successful networks of family resource programs in Connecticut and youth services centers in New Jersey.

With funding from the Pew Charitable Trusts' Children's Initiative, five States—Rhode Island, Minnesota, Florida, Kentucky, and Georgia—are currently engaged in planning a complete revamping of all services for children and families, one that will feature local, universally accessible family centers as hubs for the whole system of services and neighborhood outposts for encouraging healthy development of children and healthy functioning for families.

The documented success of a number of early childhood initiatives which have included family supportive services along with parent education—Parents as Teachers in Missouri, HIPPY in Arkansas, and Minnesota's Early Child and Family Education—have encouraged other States to use these models as well as other programs to strengthen families' capacities in new ways. The National Commission on Children's final report included family support as an important national strategy to be pursued in local communities for assuring the healthy development of children.

The State of Washington passed legislation requiring that all human services adhere to a set of family support principles, which originated in community based programs. The city of Seattle has its own family support plan. The city of San Francisco passed local legislation to support the development of family centers. The Wisconsin legislature has voted extended funding to the Wisconsin Children's Trust Fund to support the development of a network of local family resource centers.

At the National Resource center for Family Support Programs, which is operated out of my office in Chicago with Federal and foundation funds, we receive hundreds of calls monthly—more than we can adequately handle—from agencies and people involved in similar efforts, seeking to accomplish the universal, preventive functions of a family support program, along with making the whole often confusing system of services make sense from a family's point of view. We see this phenomenal outpouring of interest as a signal of the vast need for new mechanisms at the local level that are directly responsive to families and communities.

Two years ago, Federal legislation was enacted to support State networks of family resource and support programs, intended to give States resources to support networks of family resource and support programs in local communities. This year three States will be awarded approximately $1.5 million each to support their State networks. If our phone calls are any indication, more than 35 States will apply for these funds. While we are appreciative of this beginning, we believe that much more can be done on the Federal level to expand the opportunities for communities to strengthen families and change the outcomes for their children through family resource programs.

The family resource and support grants program represents a unique opportunity for the Federal Government to play a significant role in making all its services more effective for families without making far-reaching changes in the service system, and instituting an effective, family strengthening prevention agenda that is NOT tied to a specific topic or interest or funding stream. We hope that you will consider

using this mechanism as a way to create systems change where it counts: in the lives of real families in real communities.

BACKGROUND INFORMATION FOR TESTIMONY OF JUDY LANGFORD CARTER

THE FAMILY RESOURCE COALITION

The Family Resource Coalition was formed in 1981 by a group of 300 people from around the country who had started to work in their local communities with families through family resource programs. They wanted a way to share their developing knowledge about how the programs worked, and to advocate more effectively for renewed national recognition of the essential and primary role families play in producing the citizens, workers, and parents of the next generation.

The Coalition today has more than 2,000 members in the United States and Canada, strong leadership from the African American and Latino Caucuses of the Coalition, and several State level affiliate groups. Through a Federal contract, the Coalition operates the National Resource Center for Family Support Programs, which provides information and technical assistance about family support to hundreds of local programs as well as school systems, State government agencies, and innovative service initiatives throughout the country. The Coalition's multi-disciplinary, diverse board is representative of the many outstanding academicians and clinicians, local practitioners and trainers, and policymakers at all levels who are actively involved in the work of family support generally and in the Coalition in particular.

EARLY FAMILY SUPPORT PROGRAMS

Early family resource programs were mainly focused on parents with very young children, on early childhood parent education, and on support for establishing a nurturing family environment in the earliest years of a child's life. Some programs worked with teen parents to help them and their children to get off to the best start they could, providing maximum support such as mentoring and home visiting to teen moms, along with health and educational services, and intensive parenting education. Many early programs served middle class parents who often found themselves far away from extended family members or without a strong network of friends and neighbors that all of us who have been young parents know is absolutely essential to survival in the days when children are very young. All programs provided a wealth of information about child development, activities for children and parents together, and most important of all, a warm environment where parents could feel comfortable asking questions, seeking—and getting—help when they needed it, and feeling that in at least one place in their communities, someone understood and valued the work they were doing as parents.

The early programs developed in diverse settings in response to local needs: free-standing local community organizations such as those funded by United Ways, churches of all kinds and church-related organizations, parent groups that emerged from hospital-sponsored programs such as daze Groups, and many voluntary groups of. parents who had banded together to give each other support as they struggled with establishing their families. Very few of these programs received any kind of government funding, relying primarily on parents fundraising and donations from local supporters and foundations. Family resource programs which served teen parents or parents with special needs children sometimes received funding or staff services from State or Federal sources for serving these families.

CHARACTERISTICS OF PROGRAMS

Family resource programs are all unique. They are responsive to the communities and families they serve, and there is no one single model they follow. Programs which are part of a state or local initiative, and which may share some program elements in common, are still likely to be quite different, depending on the parents they serve and the community in which they are located. In spite of the uniqueness and diversity, there are some characteristics almost all programs share:

(1) Programs are based on the belief that parents are the most important resource, advocate, teacher, and guidance expert a child can have. The job of a professional in a family support program is to help the parent be all those things, on the parent1s own terms, not to take on the job themselves.

(2) As a preventive program, family resource programs are open to all parents and not based on eligibility requirements of any kind. Programs begin with the assumption that EVERY family needs some kind of support at some time. Programs may provide access to other services that DO require an eligibility test, such as WIC or JOBS, but the essential parent support services are not based on eligibility.

(3) Family support is not viewed as a service, but as a way of working with families. Its purpose is to help families use all the possible resources in the environment to support their child's development, beginning with whatever resources the family brings to the table. A primary resource is the network of informal support that exists in every community, through friends, churches, clubs, and other points of connection. The family support program's job is to help families who have trouble connecting with these resources build their own support networks, using what is available in their own communities.

(4) Family resource programs work through empowering parents to strengthen the community around the family as well as the family itself, believing that communities share responsibility for nurturing children along with families.

FAMILY RESOURCE PROGRAMS IN 1993

As the concept of family support has gained widespread acceptance, funding and program components for community-based programs have grown dramatically. A single program today may be receiving funds from maternal and child health, JOBS and other self-sufficiency programs, substance abuse prevention, child abuse prevention, mental health and educational programs, in addition to local fundraising. Programs may be operated directly out of schools, health clinics, mental health facilities, or housing developments. Federally funded comprehensive child development programs, now in nearly 40 locations, are examples of the most comprehensive family support programs.

The more recent availability of public funds for family support programs has not diminished the local partnership building that has characterized programs from the beginning. Programs still rely heavily on local resources for filling in the many gaps left by categorical funding or funding based on eligibility standards. They utilize "borrowed" staff from other agencies, volunteers, space in many locations, and local fundraising as a normal part of business. The resources of parents themselves are consistently relied on as the most significant resource of all.

Senator DODD. Margaret, thank you for being with us.

Ms. WILLIAMS. Thank you. Thanks for inviting me.

Senator DODD. I like young people with gray hair.

Ms. WILLIAMS. I do, too. [Laughter.]

We are delighted to be here. Shurnice Mackey and I came from Maryland this morning, and we are going to talk about what we do in Maryland in terms of family support. But I could tell, Senator Dodd, from your introduction and from the questions you have asked that you understand this—you get it—you have created the Family Resource and Support Program; you are going to do it, and I applaud you, and I want to give you every bit of support I can.

As long as I am here, though, I will just take a few moments to outline again what we are doing and to tell you some of the things I think are most important to keep going.

In introducing me, I think you mentioned the Innovations in State and Local Government Award and said that I'm here to tell you how government has done this. I think, paradoxically, the fact is that government isn't doing it, and that is part of the reason why it is probably working pretty well in Maryland.

Government is a partner in this, but we have a real important three-way partnership of the government, the State, and five different State agencies, and the private sector, other private funders, foundations, national and local, and individuals and corporations. But the third and perhaps the most important and unsung partner is the communities in Maryland. Family support centers in Maryland are community-based and community-controlled, and the communities themselves have to put resources on the table, both cash and in-kind, to make this work.

Senator DODD. And I can't tell you how much I support that.

Ms. WILLIAMS. It's a wonderful model. It works so well because there is buy-in at every level, there is responsibility at every level, and there is authority at every level.

Senator DODD. And you get the taxpayer involved. I remember, back a decade or more ago, debating and arguing with good friends where we subsequently agreed but fought over this very point. I remember in 1975 arguing with people at the local level that while I'm a good vote, and I help you get the funding, the fact that you don't involve the community will spell disaster at one point, where it will become very attractive to go after programs that the average taxpayer doesn't understand, because we aren't engaging and involving them—things like HUD, AFDC—what does that mean to a person who doesn't deal with these things?

And we have seen the price we have paid, because frankly, the average taxpayer had someone come along who said these are all bad ideas, it is the government, they don't know what they are doing, and there was no local knowledge of how these programs were working or why they were investing in them, and support collapsed there for a while.

So aside from what you have just said, I can't agree with you more about how critically important it is not just for a funding resource, but to sustain long-term political commitments; that the person who finances this, whether it is the Federal money or the State money or the local money, is the average taxpayer in this country, and they want to know why it is a good investment.

Ms. WILLIAMS. That's exactly right. You have to broaden that base of support, and everybody has got to be involved and believe in it.

Senator DODD. Yes, absolutely. I didn't mean to interrupt. I apologize.

Ms. WILLIAMS. No, no. You are giving my speech for me. You did it from the moment you walked in here. I'm a happy person.

Maryland's family support initiative began in 1985, and it really grew out of our growing infant mortality and teen pregnancy rates, which were at that time among the highest in the Nation, and we still aren't real proud where we stand in the line-up of States. We are about halfway; we are about the 25th State ranking in those areas.

Also, growing numbers of child abuse and foster care placements, and knowing that adolescent pregnancy and parenting is linked with the increase in child abuse, family service providers reached the conclusion that, aha, families are in trouble, and they need support if we are going to avoid this.

Senator Coats questioned one of the panelists about how in the world can we afford these incredibly expensive programs for people who are involved in substance abuse and have families. That's a tough question. I can't answer that, but I can tell you one thing, that we have to get about the business of preventing that from happening. And family support and prevention is a way of doing that. You can prevent bad outcomes for families if you get in early enough, and in Maryland, that is what we do. We put our resources in very young families, adolescent families with very young children—the two most vulnerable populations—and we do whatever

we can to support those folks to move along toward self-sufficiency and economic independence.

The family support network in Maryland now numbers 15 centers. We are located in very rural settings, in urban settings, and in some ex-urban settings, including suburban Prince George's County.

Our network is administered by Friends of Family, for whom I work. We are called an "intermediary." We receive funding from a number of different sources, as I explained, and then we give it out to a number of different sources. Besides just being a pass-through for funds, we do a number of other activities, which I'll get to in a moment.

Basically, here is how our process works. When we get enough money together from all our funding sources, which is roughly $200,000 a year per center, we send out a request for proposals and any private or public nonprofit organization can submit a proposal to operate a family support center. Selected sponsoring organizations currently include the Bethel A.M.E. Church, and Shurnice is here as a participant—originally a participant, now an employee—of the Teen Enrichment Parenting Program, which is Bethel A.M.E.'s family support center.

The YWCA of Annapolis and Ann Arundel County runs a family support center; Human Services Program of Carroll County; a community college, Cecil County Community College; a board of education, Dorchester County Board of Education, runs one; Associated Catholic Charities runs one; we have had a black sorority run one. They are operated by a huge variety of community-based organizations that have a stake in the community, a commitment to the community, and know the players.

Each center receives roughly $180,000 to $200,000 a year through us, and in order to run, a family support center really has to raise another $100,000 or so itself in cash or in-kind—the in-kind largely comes in the form of donated space—per year.

Centers are roughly 4,000 square feet in size, and we expect them to see about 100 families intensively every year, which means a family coming regularly, at least once a week, every month.

Centers are required to offer a range of services, open on a voluntary, no fee, elective basis. Structured classes and groups are offered in addition to drop-in services. The set of core services offered at every family support center include parenting education; child service for infants and toddlers while their parents are onsite; health education and referral for the full range of health care services; educational and employability services. And Shurnice might want to touch on a few others that are offered at Bethel.

Centers are also free to do other services for other populations besides young parents with young children. Some raise extra money to do special classes for parents whose children are in foster care. Some raise extra money to do literacy programs for the elderly in the community. Some have grandparent programs, and so forth.

Friends of the Family, the intermediary, provides technical assistance and training to the center. Our areas of expertise are in infant and toddler development, social work, counseling, education,

funding proposal development, organizational development, strategic planning, and those kinds of services.

By having the technical expertise kind of centered in the intermediary, it means that the community-based programs can hire people from the community who don't necessarily have a lot of advanced degrees, but can get the kind of training needed to bring their practice up to par. One of the hallmarks of Maryland's program is that it is a very high-quality program. If it is worth doing, it is worth doing right, and we don't want to do it skimpy; but by the same token, we want local people involved. I know Senator Wellstone raised this issue. It is really important to have people with a stake in the community involved in running, managing and making decisions about programs, and if they don't have the training to do it, let's give it to them on the job.

Friends of the Family also collects data on family support centers programs and participants through a computerized data management system, funded by the Ford Foundation. We have state-of-the-art equipment that gives us data not only on who is coming and what are they doing, but what are some of the outcomes.

Our accomplishments—we will celebrate our 7th birthday this year—but in just a recent 12-month period, 83 percent of all of our support center participants who were teenage parents and who had dropped out of school because of their babies or for any other reason are back in a high school alternative program of one sort or another, on their way back to education.

Ninety-three percent of all the children who come to family support centers from ages zero to 5 are up to date on their immunizations. That's against 56 percent in our State statewide, and that 56 percent, of course, is all kids—my kids, everybody's kids, in that 56 percent. At family support centers, 93 percent.

Senator DODD. Yes. We've heard about 63 percent overall in Connecticut, and we're among the highest in the country. And our State buys the vaccines. There are only a few—I think four States—and Connecticut is one of them. And we are only at 63 percent.

Ms. WILLIAMS. And this goes back to another point that either you made, Senator Dodd, or Senator Wellstone, that we don't do immunizations at family support centers. We empower people to get it for themselves. We coach them and encourage them, and actually, it is through heightening their awareness of the development of children and the importance of the care of children, of their own children, and the excitement and pleasure of it that people themselves feel motivated to go and get some of this stuff done. Where we find barriers—and one of the panelists talked about the unavailability of medical services in rural areas—we have that in Maryland, too.

Senator DODD. I'd like to ask you about that, because we are going to deal with this immunization issue, and they are talking about spending $1 billion. And I am very much in support—clearly, I think most people are—of trying to make it more available. I think it would be worthwhile if you could even submit some written testimony to me on that aspect, because I'm of the mind that our problem is not necessarily making more vaccine available, but rather, getting people matched up to where they are. Obviously, it

is a factor, the cost and the availability, but I am wondering if we aren't placing the emphasis on the wrong side of this equation—given the Connecticut experience where it is available, and yet we are only at 63 percent. If we do more and better outreach, getting people to be aware of it, and where they can go, and how they can do it easily, we might raise those numbers up substantially at not quite the same cost, and you could actually take those resources and put them to work in some other places in terms of the dollars—which is what you are sort of telling me, in effect.

Ms. WILLIAMS. Yes, it is. And in the cases where there has been an unavailability of services, the intermediary, Friends of the Family, will help the community itself get for the community as a whole what it needs. It isn't necessary for us to collocate or to provide the service ourselves, but to facilitate the development of that for all children.

Senator DODD. In fact, that's a disservice, in my view, because part of the process is teaching people how to fend for themselves, not just in this setting, but once they get beyond this, hopefully, where they start taking care of their own lives without any kind of support center at all, that they have learned how to do it—getting rid of the crutches.

Ms. WILLIAMS. Yes. And people are able to do it. I mean, people can do it and are willing to do it. It's just a question of sort of triaging the issues that they are facing and helping them work through them one at a time, instead of feeling overwhelmed.

Senator DODD. That's right.

Ms. WILLIAMS. What has made our program a success, I think all the factors have been touched on; Judy raised a few of them, the hallmarks of what family support is. Staff-participant relationships are equal; they are supportive. Centers are warm and comfortable, they are inviting, they are supportive. The centers emphasize the value of peer support and professional support. They reflect that all of us need support at one time or another, and that it is fine and good and healthy to ask for support and also to give it.

We do not presume that we know how any family or any community or any center works best; we accept that as families change, so should the programs, and we together as a network support each other with ideas and thousands about what has worked and what hasn't worked.

I can't emphasize enough what I see from a number of points of view is the value of this intermediary model we have. By nurturing the partnership among the public and private sectors and local communities, by maintaining the integrity and the cohesiveness of the network, despite enormous variations from center to center, we have maintained what you said right at the beginning, Senator Dodd, enormous community-based support for family support in Maryland.

When our State is cutting every program at the State level that is not mandated, and the State isn't under any mandate or order to provide—they are cutting it off because of the budget situation—family support in Maryland has grown. The per-center budget from the five State funding partners has grown, and the number of centers has grown. So it is a testament to not only how well it works, but how much it is appreciated by the people and the communities.

Obviously, we are a symptom of systemic change in Maryland. The most significant aspect is that State partners give their money to me, a private, nonprofit intermediary; they trust me to get their mission accomplished, and I give it all away, or almost all of it away, to community-based programs, and I trust them to appropriately serve by their own lights young families with very young children. We trust each other to do that; even though all our missions are slightly different and all our goals are slightly different, we work together to try to strengthen Maryland's families.

I have also already mentioned decisionmaking in partnership, which is another indication of systemic change. But the third area that I want to emphasize, and I think Judy touched on this, is that Friends of the Family stresses that partners at each level must model the kind of behavior they expect each of the others to exhibit. For instance, we hope that parents will understand and respect their child's needs and empower the child to act responsibly, on his own or her own. We expect that center staff will show that same kind of consideration and sensitivity toward participating parents and that sponsoring agencies will show a parallel regard for their center staff, and that Friends of the Family will honor community needs and preferences to enable centers to act accordingly, and that funders, public and private, of this whole initiative will trust the intermediary to act responsibly.

After almost 7 years in the family support business, Friends of the Family and all of our many partners have a few comments to offer as we go forward. We have learned that there is a great interrelatedness of family needs and that many kinds of services are needed by families—education, health, those related to economic well-being and the quality of our community life. Very often, the many programs that are designed and funded not only at the State but also at the Federal level make it difficult for State and local governments and programs like ours to provide a seamless system of services to all families. We need flexible, long-term funds that are readily available, without restrictions on who can use the programs, especially income restrictions. The Head Start restrictions, for instance, make it real difficult for me to integrate family support for zero to 3-year-olds with the Head Start for 4- and 5-year-olds—but I'm trying.

At any rate, there are little bits and pieces of solutions buried in programs all over Capitol Hill and all over Annapolis that we can put together and do the job, but all the restrictions and labels and goals need to be loosened up a little bit so they can flow through more amorphous and less-prescribed locally-controlled family support programs.

As I indicated, the best thing the Feds could have done for family support is to create the Family Resource and Support Program, and I thank you for that. All I ask now is that you fund it adequately, so all of us can use it. There are going to be 25 or 30 of us competing for $1.5 million. It isn't enough, and yet we know it works. This thing needs to be taken to scale.

And speaking from the State perspective, as generous as Maryland has been to our initiative, we aren't going to be able to get this to scale without Federal support. And I need a national partner in my picture in order to keep the pressure on the State and

the locals; so you've got to come to the table. You are at the table—I just hope you are at my table. [Laughter.]

Just two last points. An issue we face routinely is the difficulty of finding the right people for family support. I think there is a big market here. I think there is a future for people who want to get into the business of working with families and children from an empowerment standpoint.

Finally, our family support centers are typically located in so-called at-risk communities. We look to be in places where we think we can prevent bad outcomes for families. But I would argue that all families need support and that therefore we should have a universal access program for family support and funded that way. In Maryland, as I said, we have targeted these centers geographically—anyone can come to them without any restrictions, but because of where they are, it is obviously likely that only some people will come. This contributes or could contribute over the State level to kind of stereotyping who a family support center is for and what kind of person comes to a family support center. Ideally, the whole Nation should shift to a broader eligibility and perception of what it takes to raise a healthy family and to support parents and children and grandparents and friends in the raising of children.

I really appreciate this time that you have given me, and I think I'll turn it over to Shurnice now to tell her perspective, where the rubber meets the road.

Senator DODD. You are a great witness, Margaret, and you know it all. I had all these questions for you, and you've answered each one—I was checking off these things going down. I thought I was the originator of the idea of the seamless garment, but you've picked up on it. I use it all the time.

[The prepared statement of Ms. Williams follows:]

PREPARED STATEMENT OF MARGARET E. WILLIAMS

Mr. Chairman, distinguished Senators, ladies and gentlemen, it is indeed a pleasure to be here representing Maryland's Family Support initiative. I have been asked to describe how Maryland's Family Support Centers work to strengthen families in Maryland and to outline how Maryland views our family support network as part of a systemic change in the way our State provides services to families.

I shall begin with a brief overview of our network how it is structured and what services it offers to families. I shall then turn to a reflection on lessons we've learned about family support and where we need to go in the future, in terms of program enhancement and expansion.

On September 26, 1991, Friends of the Family was awarded one of the most prestigious honors in the Nation for human service programs, the Innovations in State and local Government award. Bestowed jointly by the Ford Foundation and the John F. Kennedy School of Government at Harvard University, the award recognizes "Ten Shining Examples of Government at its Best" each year, and includes a $100,000 prize for each recipient.

In grating the Innovations Award to Friends of the Family, the judges concluded that Maryland's forward-thinking public/private/community partnership represents an important new direction in the provision of preventive social services to high-risk families. They were impressed by the organization's flexibility, the use of an intermediary agency to represent the interests of the State and its private sector partners, the focus on very early intervention with infants and toddlers, the comprehensive nature of Family Support Centers, and their ability to motivate parents to complete their education, seek employment and strengthen their parenting skills. I am sure the members of this subcommittee are aware of some of these strengths, because Friends of the Family and Maryland's Family Support Centers were the model for legislation enacted in 1990 to fund similar State systems.

HISTORY

Maryland's Family Support Center (FSC) initiative was established in 1985 in response to Maryland's growing infant mortality and teen pregnancy rates, among the highest in the Nation, and child abuse reports and- foster care placements, both growing at an alarming pace. In view of statistics that link adolescent pregnancy and parenting with increases in the incidence of child abuse, family service providers reached the conclusion that the family—the nurturing unit of parents and children—was in a state of crisis.

A handful of family service professionals at the community level formed a partnership with the State of Maryland and the Aaron and Lillie Strauss Foundation and the Morris Goldseker Foundation with one very ambitious mission in mind: to strengthen families of Maryland's children, particularly those in "at-risk" communities. Our Family Support Center network and Friends of the Family are based on the partnership's realization that as family problems increase, so do many of our social problems. Our State's solution was to develop a support system for families to help them raise healthy children and build productive futures. Just as pragmatic as they were idealistic, the public, private, and community partners realized that in saving our State's most precious resource its residents—they would ultimately save Maryland's financial resources.

The goal of our network is to provide comprehensive, community-based, preventive services on a drop-in basis to families who live in neighborhoods that show high concentrations of adolescent pregnancy, poverty, low birth weight babies, high school dropouts, child abuse and neglect, and unemployed adolescents and adults.

The Family Support Center network—low numbering fifteen funded Centers located in urban, rural, and suburban settings—is administered by Friends of the Family, a non-profit corporation for whom I work, with funding from the Social Services Administration of our State's Department of Human Resources and private foundations, corporations, and individuals. In addition, we receive ending for Family Support Centers from three other State agencies: the Maryland State Department of Education, the Governor's Office for Children, Youth, and Families, and the Department of Health and Mental Hygiene.

In the first year of funding (1986), the network received $300,000 that was allocated among the four original Family Support Centers and the intermediary, Friends of the Family. These initial funds came from the Department of Human Resources and the Strains and Goldseker Foundations. Subsequent funders of the network have included The Ford Foundation, the Abell Foundation, The Public Welfare Foundation, and the Fannie Mae Foundation.

CURRENT STATUS

This year, for the period from July 1, 1992 through June 30, 1993, our budget is over $4.7 million to operate 15 Centers. We expect to grow to 19 Centers by June 30, 1994, with a budget of $5.5 million.

Here is how the network operates. Family Support Centers are selected through a Request for Proposal (RFP) process. Friends of the Family (FOF) promulgates an RFP to which public and private non-profit organizations may respond. A review panel, comprised of experts in such fields as adolescent pregnancy, early intervention, and community development, reviews the proposals and makes recommendations to Friends of the Family for selection. Selected sponsoring organizations currently include: the Bethel AME Church, the YWCA of Annapolis and Anne Arundel County, Human Services Program of Carroll County, Cecil Community College, Dorchester County Board of Education, and Associated Catholic Charities.

Each Center receives approximately $180,000 per year from Friends of the Family for the support of operations and must raise another $100,000 in cash and/or in kind, in order to run a program that will serve roughly 100 families per year intensively (at least once a week each month). Centers are usually 4,000 square feet or less in size.

There is ongoing involvement on the part of participants, sponsoring agencies, staff, and the community in program design, implementation, and modification of programs offered at Family Support Centers. This ensures that the programs remain responsive to the needs of the participants and the community. Further involvement is formalized by the establishment of a community board for each Center. The board plays an active role in program planning, promotion, and growth.

The current Centers offer a wide variety of services delivered on an elective basis. Structured classes and groups are offered in addition to drop-in services. The set of core services offered at every Family Support Center are: parenting education; child care services for infants and toddlers through 3 years of age while their parents are on site; health education and referral for a full range of health care serv-

ices; educational and employability services provided on site and through referral; recreation for parents and children; service coordination with other agencies; developmental assessments for children and remediation of developmental problems either on site or by referral; advocacy and community-building; short-term counseling on site and by referral for more intensive counseling services; adolescent pregnancy prevention services to delay both first and subsequent pregnancies; and in-home services for hard-to-reach families.

Some Centers offer additional programs to fit their community's unique needs and seek funding to develop and sustain these programs. Examples include the Nurturing Program, a child abuse prevention parenting service; support groups for interracial couples, children of alcoholics, grandparents who are parenting, parents whose children are in foster care, foster care parents, new workers, and fathers, various preteen and teen clubs and activities—including theater, dance, and jobs clubs; tutoring and summer camps for school-aged children.

To insure that the family support initiative would grow and that the Centers would receive the support, technical assistance and training they require, the funding partners established Friends of the Family which serves as an umbrella organization, promoting a quality delivery system while advocating and promoting the need for other programs that strengthen and support families with young children.

Professional staff employed by Family Support Centers come from a broad array of disciplines, including child development, education, health, housing, social services, recreation, and mental health. No one discipline dominates this initiative. Paraprofessionals and volunteer staff are heavily utilized in the Centers. Professional staff provide training and supervision for other members of the Center team.

Friends of the Family provides technical assistance in infant and toddler development, social work, counseling, education, proposal development, organizational development and strategic planning to Centers as needed and through regularly scheduled site visits, joint meetings, and in-service training. FOF technical assistance staff also monitors Center programs to ensure program quality and consistency throughout the network.

Center directors participate in monthly information/training meetings coordinated by FOF, designed to build linkages and program strategies, and to facilitate information sharing/problem solving among Centers. In addition, there is an annual 2-day training program, jointly planned by Center staff and FOF, attended by all staff members, and open to Center volunteers. Program staff are encouraged to establish relationships with other programs whose goals and services are similar in order to share information and to advance the field.

Friends of the Family also collects data on Family Support Center programs and participants through a computerized management information system. Developed by Friends of the Family with a Ford Foundation grant, this state-of-the-art data entry and reporting system is designed to provide monthly data on services received by thousands of participants in Maryland's Family Support Centers.

ACCOMPLISHMENTS

From November 1, 1991, through October 31, 1992, the Family Support Centers (the 10 that were each open for a full 12 months) served 4,185 parents, young children, and non-parenting participants. Here are some important results:

Eighty-three percent of Family Support Center participants who are teen parents and are not high school graduates are enrolled in school or alternative high school courses leading to a GED.

Ninety-three percent of children from birth to age 5 who visited a Family Support Center during this period had up-to-date immunizations, compared to 56 percent statewide.

No child in any family participating at a Family Support Center was removed from his or her home, and 48 children were returned from expensive foster care to their families.

Of the estimated 361 parenting teens under age 19 who came to Family Support Centers during this period, only 24 had repeat pregnancies.

SUCCESS

What makes Maryland's Family Support Network so successful? A number of the elements of the design contribute to our ability to attract and maintain the participation of a traditionally isolated population and to support them it, their efforts to move toward economic independence and selfsufficiency.

All Center activities, communication, and participant/staff relationships incorporate a preventive approach which seeks to develop the strengths of participants and communities.

Each Center—whether housed in a school, a storefront, or a community center maintains an informal, comfortable, welcoming, and homelike environment. Specific attention is given to providing space appropriate for the needs of infants and toddlers. Centers are open a times convenient and realistic for participants, including some evening and/or weekend hours.

Centers emphasize the value of strong peer and professional support. They reflect the premise that all families need support at some time and that sources of support should be available in the neighborhood and local communities.

The principles of family support, including partnership in decision making and flexibility, are critical to the process: in the development of the program in 1986 and at all levels of operation currently, we strive to get to "yes" by incorporating ideas from all stakeholders. We do not presume that we know how any family or ally community or any Center works best, and we accept that as families change, so should the programs that we administer.

The intermediary, Friends of the Family, by nourishing the partnership among the public and private sectors (funders) and local communities and maintaining the integrity and cohesiveness of the program across the network, despite significant variations in sponsoring agencies and program designs, has maintained solid community-based support while delivering performance for the funders. Also, the strong technical assistance component provided by the an intermediary supports the Centers. Centers, like families, need to be part of a larger network; that is how relationships grow and allow each member to flourish.

SYSTEMS CHANGE

Our initiative in Maryland incorporates perhaps the most important—and difficult—aspect of change: multiple State and private sector partners have turned over their money to an intermediary, who in turn contracts with community-based sponsoring agencies. Though each entity involved has a different mission and goals for itself, each pledges to use/provide the funds for the same purpose.

I have already mentioned another important aspect of systemic change: decision making in partnership. Which and how programs are to be run are decisions made by parents and Center advisory boards, staff at Family Support Centers, FSC sponsoring agencies, Friends of the Family and the funding partners. Each has a slightly different amount and kind of authority and responsibility in the decision-making process, but each is involved.

Friends of the Family stresses that partners at each level must model the kind of behavior that they expect others to exhibit. For instance, we hope parents will understand and respect their child's needs and empower the child to act responsibly. We expect that Center staff will show that same kind of consideration and sensitivity toward participating parents, that sponsoring agencies will show a parallel regard for their Center staff, that Friends of the Family will honor community needs and preferences and enable Centers to operate accordingly, and that funders will trust and enable the intermediary to act responsibly.

NEEDS AND RECOMMENDATIONS

After nearly 7 years in the family support business, Friends of the Family and our many partners offer our comments on our performance and our requirements as we head into the future.

We have learned that there is a great "inter relatedness", of Family needs, and that many kinds of services are needed by families, including those related to parenting, education, health, economic well being, the quality of community life, and so forth. Very often the many programs designed and funded by the Federal Government in these areas make it difficult for us at the State and local level to support families by providing a "seamless system of services." We need flexible, long term funds that are readily available, i.e. without restrictions on who can use the program, how they can use it (duration and intensity), and how it can be combined with other programs. There are solutions to family dysfunction spread all over Washington (and Annapolis): none are big enough to do the job alone but with added flexibility and leveraging, these programs can be used to get the job done efficiently and effectively.

The best thing to happen to family support in Maryland since we were created is the Family Resource and Support Program that you created! Please fund this adequately so that all of us can take advantage of it. This year, over a dozen States will be competing for one of three berths, each funded at roughly $1.5 million. It's not enough—by a long shot—and yet the argument to create, enhance, and expand family support programs is overwhelming. Our State—as generous as it's been to our initiative—cannot get our network to scale without Federal support. If there is

a national partner, our State and local partners will stay in this venture. We need you at the table.

An issue we face routinely is the difficulty of finding the right people to work in Family Support Centers and at Friends of the Family. We need people who understand the philosophy of family support, feel comfortable in this different way of relating to families, and have adequate formal training in infant development. Colleges and universities must recognize that we are creating a new job market.

I would argue that all families need support and that therefore we should have a universal access program for family support. In Maryland, we have targeted programs for at-risk families and in some senses, this contributes to the stereotyping of our service and the possible labeling of participants. Ideally, we should shift to a broader eligibility standard.

I hope I have given you a useful overview of Maryland's family support initiative and a sense of the power of this way of strengthening families. I hope I have also left you with some guidance as to how the Federal Government might be helpful to families and community-based organizations as they go about their important work of leveraging resources from everyone and building communities, one baby at a time.

Senator DODD. Shurnice, thank you for coming. You are our clean-up hitter today; it all hangs now on you.

Ms. MACKEY. I am here to tell you about the Teen Parenting Enrichment Program which I attend and how I got started there.

I found out about the Teen Parenting Enrichment Program from a friend because I wanted to enroll in a GED program. I am still attending the program, and it has been a year now.

The difference it made in my life is that I now have a job at the teen parenting center, working with the infants and toddlers. The director gave me an opportunity to believe in myself, and I can do many things if I try. I feel very good about myself as a working person and a mother. I love working with children.

The teen parenting center has nice support programs. They also have several support services such as group and individual counseling, parent education, assistance in finding housing, substance abuse counseling, employment assistance, life skills training, a prenatal program, and pregnancy prevention education.

The teen parenting center needs additional space and funding so that we can serve more mothers and children. Many young parents could be successful like myself if they received more support in trying to accomplish their goals.

Senator DODD. Thank you very much. That was very helpful.

How long have you been with the program, both time in and time working, all together?

Ms. MACKEY. I have been at the program for about a year and 5 months. I just started working there in August of last year, and I had been going to the training classes, and I also volunteered before I got the job.

Senator DODD. Good. Where did you look before, Shurnice? You said you were interested a GED program. Did you try other places?

Ms. MACKEY. No, I didn't try anywhere else. It was just a friend who had told me about the family support center, which was close to me, so I went and checked it out, and I have been there since.

Senator DODD. What do you think would have happened if you had not found that particular center?

Ms. MACKEY. Well, if I hadn't found it, I probably still would not be enrolled in a GED program; I would probably still have been sitting home, not working, and not wanting to look for a job or to

have a job. But they made me feel good about myself when I enrolled in the program.

Senator DODD. Terrific. I appreciate your being here today. Again, as Ms. Williams pointed out, there all these people who work in these programs, and those of us up here who try to understand and translate the needs out there into legislation, but you are really what it is all about, and if it doesn't work for people like you, then all of our good intentions and best efforts up here don't mean anything. So at the end of the day, it has to do something for people like yourself and take you someplace and move you on; if it doesn't, then it isn't working. So it is very important to have your testimony and your ideas as to what you would like to see. Are there any changes that you would make in the program; are there things that could be done better; are there any thoughts you have coming out of this?

Ms. MACKEY. If we could get more funding, we could probably get a bigger building, because like I was talking about the space. Sometime, when we get a lot of parents and children in, it gets crowded, and we just run out of space. But we also help them and see them there. So I would say more funds would help out.

Senator DODD. I understand that, and as I pointed out earlier, we get a lot of requests up here, but I think one of the things we need to do on this—and I might ask you, Margaret and the two Judys if they want to comment—I think we can make a stronger case for this if we could begin to look at administrative cost savings. Again, the constituency that we have to relate to here is the taxpayer constituency, and I work on the assumption that these are good people who are willing to support things that work. I mean, if I hear anything when I go around my State and talk to people about things, it is not that they are opposed to those ideas at all—in fact, they are very supportive; when you start talking about education and health, I rarely run into people who say they are opposed to doing anything in those areas—what they want to know is what works. If you are going to take my tax dollar and put it to work, where does it do the most good, and how do you maximize the dollar? I'd like my dollar to reach people rather than end up as being part of a bureaucracy. You hear this about foreign aid, and you hear it about everything—and with foreign aid, you have some people who are just opposed to foreign aid, so they don't like the idea of it going anywhere. But here, people like the idea of the money going someplace, but they want to make sure it works right. I wonder if we have done any work—and maybe I should know this—in examining a cost-benefit analysis of the centralizing seamless garment approach so that you then tremendously reduce cost.

One of the things we will do, I suspect, is if this works, we will increase the number of people getting what they are supposed to get in order to make this work—which maybe some people are worried about happening.

Ms. CARTER. That actually does happen. When I was at the Ounce of Prevention Fund in Illinois, one of the things we did was support a network of local programs much like Friends of the Family supports in Maryland, and in a couple of rural areas, where we got enough people actually accessing the services to which they were entitled, the State made us stop doing that because it was

really costing them more money to actually make sure that people got prenatal care, and they got WIC, and they got all the things that they are really entitled to have. But I think that is one of the early problems of actually accessing the services.

Senator DODD. Too much success.

Ms. CARTER. Too much success really causes problems.

Senator DODD. Do you want to comment on that, Margaret?

Ms. WILLIAMS. I was going to say that I can think of several examples where there have been not only administrative but programmatic cost savings as a result of combining programs.

Senator DODD. It might be helpful to get that. I hope I'm not overstating the case here, but I really sense this attitude among my constituents—and in my State right now, people are really hurting economically; we have lost a lot of jobs, and there is a tremendous amount of economic pressure in the State, as I go around and talk about where the priorities ought to be. I spoke at a joint Chamber of Commerce meeting in Fairfield County on Monday, and this is the more affluent part of my State, traditionally more conservative politically. We were talking about where investments ought to be made, and when I talked about the health and education areas and so forth, I got complete support from this constituency—this is a business community in a relatively conservative area of my State, and there was no objection. They just want to make sure it works, and that it will produce the desired results.

So I think you'd have little opposition, in fact, even for additional funding, provided it was really reaching people and making the difference and having the kinds of results that Shurnice has been able to demonstrate with her testimony. It is critically important.

Prevention obviously is the key here in so much of what we are talking about, and prevention includes the entire family. We heard eloquent testimony earlier about the importance of that from Lisa and others, of bringing in the families, and I think that concept is really beginning to penetrate people's minds in some of the more sophisticated private programs in the country, dealing particularly in the substance abuse area today, where they caught onto that concept a long time ago. We are really behind the curve in a sense, in a public way, in those areas.

Friends of mine went through this recently—a very affluent family, kind of like what Dan Coats talked about; they were out in Minnesota at a well-known program there, and they all came back with t-shirts, the entire family, that said, "Denial is not a River in Egypt," indicating the denial of the family in this sort of issue. So we've got to involve more people in that if we can.

I wonder if you might talk a little more, Margaret, about the substance abuse aspects of all of this and tie that in.

Ms. WILLIAMS. Yes. Substance abuse is a tricky subject for us in Maryland at family support centers. I would second everything the panel you had here earlier today said about treating parents who have substance abuse issues, about the need to work with them and their children together in a residential setting; I think that's the way to go.

We have six family support centers in Baltimore City, and all six of those receive extra funding through us for substance abuse coun-

selors, because it is such a prevalent problem in many, many, many neighborhoods in Baltimore City.

We aren't funded or equipped to handle the substance-abusing parents very well, especially those whose problems interfere with normal living and responsibilities—but there are very many of them, and when you start successfully counseling them and their friends, then you get a lot of substance-abusing families coming in to the center and chasing out the families who are not substance-abusing. We have actually had this happen in two family support centers in Maryland.

The problem there is that it is hard enough to reach teenage parents with babies who have dropped out of school. That is hard enough. But now, substance-abusing teenage parents with babies who have dropped out of school are even harder to reach, so when you get them into a program, voluntarily coming for counseling and peer support, you don't want to lose them. And actually, what one center was able to do was to sort of spin that off into another program all of its own, so the family support center could go back to working with families who haven't identified themselves as having any problem and who don't.

We have it. We deal with it. We talk much more about education, about living with substance abuse all around you, in neighborhoods, in your family; all family support centers do that, but treatment is another issue.

Senator DODD. Well, that makes sense to me. Are there other areas where that would hold up as well?

Ms. WILLIAMS. Well, labelling is a problem. Another area where we have to exercise extreme caution in balancing the needs of communities against the abilities of family support centers is in the area of foster care, families whose children have been removed and placed in foster care, and how to help with the reunification of families. Because we very often are the only parenting program in a community, and we do it well, and we are liked, especially our public funding partners are very interested in seeing us branch out and do more for that population. It requires a more therapeutic environment to some extent to do that well, but it is also very hard to mix those populations—parents whose children have been removed—and so it requires different kinds of programming, space and staffing. It is a resource limitation. And then there is also the programmatic impact of that and how you can do it.

It is tough to balance, but that is another stress—substance-abusing and then families who want their children back.

Senator DODD. Shurnice, you mentioned some of the problems, like space—and each case is different, obviously—but what were some of the things you found most helpful for you in the program?

Ms. MACKEY. The GED classes helped me, and also the counseling—because if you needed to talk, someone was always there to talk to you, no matter what the problem was. They also have the parenting skills classes there, where they talk about disciplining your child, and relationships, and anything else that you wanted to talk about. There was just always somebody there to talk to you, to make you feel good.

Senator DODD. And that was helpful to you.

Ms. MACKEY. Yes.

Senator DODD. How old is your child?

Ms. MACKEY. At the time I attended the center last year, I had twin girls, and they were 3. So they are 4 years old now, and they go to the Head Start program.

Senator DODD. That's a lot to take care of. How are they doing now?

Ms. MACKEY. Fine.

Senator DODD. And they're in the Head Start program?

Ms. MACKEY. Yes.

Senator DODD. How do you like their Head Start program?

Ms. MACKEY. I like it; it's fine.

Senator DODD. Good. There have been some criticisms of it lately by some people as to whether or not it is working well.

Ms. MACKEY. Well, the one they go to is nice. They go to the one called Union Baptist Head Start in Baltimore, and they take the kids on trips and so on, and I see that they have learned since they have been going there.

Senator DODD. Good; that's good to hear.

I wanted to talk with you about the delivery systems with you, Ms. Moler, and you are right—I think we have heard today that there are a lot of different approaches here on how some of this stuff can work and how you can integrate them, and which ones can be integrated, and in some cases, which ones cannot, and I think it's important to talk about that, and find different ways for government to work together. This whole issue of governance is a problem in any area, but I think here, we can end up sort of tripping over each other a bit. We need to know ways we can avoid that, particularly when you get into public and private initiatives and how they come together.

I wonder if you might speak a bit more specifically to us on how you think the delivery systems might be improved to accomplish this.

Ms. MOLER. I think one thing you said earlier is really important, and that is to bring players to the table who haven't been there before, to educate them—the business partners, the consumers themselves, and the advocacy groups—and to have their input.

The other thing—and this is a very scary thing to lots people—but I think the more local control you can invest, that is important, because what plays in Osawatomie, KS is not necessarily going to work in Chicago, IL. And just as we sit together here at the table, as Margaret said, that trust level develops—I know who you are, you know who I am—and I think coming together does that, and that probably needs to happen on the State level and on the Federal level, because I know in the State of Kansas when you talk about giving local autonomy to Osawatomie, KS, that brings fear into the hearts of many.

Senator DODD. I agree with you. There is still a tremendous amount of resentment particularly about people who work in these fields—there is a fear that by opening up that door, the local people are going to come in and torpedo these programs because somehow they inherently don't like poor people, or that there are strong racial overtones—and there may be, and I am not suggesting that does not exist in some places. But for someone who is in public life, public meetings are painful. I mean, when I attend a public meet-

ing, and my constituency out there points a finger at me and screams at me over a vote I cast on some issue, or why I voted this way or that way—I would prefer that everyone came and just applauded wildly everything I was doing. But I am a representative, and I have to listen to my boss, and my boss is those 3.5 million people whom I represent.

So it is an awkward, discomforting feeling to have to go before your employer. And in a sense, the employer of these programs, if you will, is the very same employer I have, and those are the people who pay for these things. And to the extent we involve the employer, if you will, using that terminology, first, you'll find tremendously enlightened people who really do understand things, and some who are ignorant. But a small dose of education about what's going on, how it works, and where are the shortcomings, and involving them and asking them to get involved with you—I find that some of the harshest critics of various things, if you say, "Well, come to the table and tell me what you do," become the strongest advocates I have. It is some sort of relationship there, which I'm sure a psychologist could explain to me, but by reaching out and doing it, it slows it down, it doesn't get done as efficiently, occasionally decisions get made that you don't agree with—but at the end of the day, you've got a far broader and deeper base of support for what you are doing. And that makes our job so much easier up here when we go to the well.

As you point out, Margaret, in your State, this is something that not only works, but people support it. Those legislators are not up there supporting it because they necessarily think it is a great idea; it's because they have constituents who think it is a great idea. And somehow getting that through to the professionals is critically important for the success, and what you really need to know is some degree of predictability about funding streams—that winning this 1 year and losing it the next, and then getting it back can just mess these things up terribly.

So I want to underscore what you are saying here. I think it is very important.

Ms. MOLER. The other thing that I observe is that we need to learn—and I was a service provider for a lot of years—that we don't have to do it all; it is not incumbent on us to do it all. When we talk about empowering families, again, it is a trust issue—people can take some responsibility or all responsibility in different cases, and we don't have to do it all.

Senator DODD. Sure.

Ms. MOLER. And our tiny parochial profession that we do, education, doesn't have to do it all, and social services doesn't have to do it all.

Senator DODD. I was a Peace Corps volunteer in the sixties, the thing that we were taught from the very beginning, and you have heard this a thousand times, was: Which is better—to give someone a fish, or to teach them to fish? And I think that's about as simple as you can put it, obviously, teaching people how to fend for themselves. A lot of it is just fear, this fear of what do I do next. And once you have figured it out, and find the comfort zone, you enter into it, and you are comfortable with it, the sense of confidence that

you can take care of yourself and your family is just liberating, and I think it is an extremely important element.

So it is so important for me to hear you say how that works, and not just doing it for people, but showing them how it can be done. That's worth its weight in gold.

Ms. CARTER. I think there is another aspect to that that has been really important in the communities where we have seen family resource programs be a catalyst for that same kind of empowerment of the service providers, because in many cases, those are people who do their jobs well, and their system has rewarded them for not cooperating with anybody else, and for viewing a particular child as the client and not looking beyond that, because there is nothing they can do about that.

But I think what we are beginning to see—and we are working in a number of places where schools have begun to reach out beyond their walls to try to figure out what else is going on out there—but in many cases, there is no point of flexibility, and there is no incentive for any of those other systems to come together and work together for those service providers.

But we see the same kind of thing happen—once somebody figures out that they don't have to do it all and that there are other resources out there—we have heard this time and time again in Kentucky, where they have put family resource centers in all the schools where more than 20 percent of the children are eligible for free lunch. They would tell you that the most important thing about that was that for the first time, the school employees themselves knew what else was available in the community to help that kid that they were feeling very frustrated about being able to help.

Senator DODD. That's a very good point.

Ms. CARTER. So I think the family resource centers, in addition to what they do for the families that they serve, really create the kind of opportunity and catalyst for the other service providers to come around. And even in places where everybody is still doing their own little thing, it still is the first step sometimes to have them begin to do that.

Senator DODD. That's a very good point and very helpful.

There may be some additional questions that we may have for you, but just know that I am deeply committed to this. Wanda, on the earlier panel, with her daughter Michelle, asked why are we even doing this, and why doesn't everybody understand this. Well, they don't, and Senator Coats is right, there are a lot of people competing up here for scarce dollars. But I am so deeply committed to this; it makes so much sense to me as we try to achieve efficiencies and also, of course, most importantly, serve families, particularly with the desire out there. We have a number of training programs in Connecticut that are fairly successful, including the private industry councils, and I wish I could take more of my constituents—I wish there were some way they could hear what I hear from participants, the majority of whom are women, in these programs, trying to raise families and make ends meet. You could end a lot of these mindless, stupid arguments you hear about whether people really want out.

It infuriates me when networks and programs will run spots about the isolated case of the woman in the limousine or the taxi-

cab, buying the liquor and the wine—and it kind of makes the hairs on the back of my neck go up, as it would any normal human being—but if they could meet the overwhelming majority of people who are just desperately seeking the independence, the self-esteem, the sense of self-worth that they need in order to survive, it would eliminate a lot of this garbage we hear all the time.

And obviously, these centers in my view are the way to go, so just keep working at it, and we'll get there, we'll get there.

I thank all of you for coming this morning, and my colleagues may have some additional questions as well, so we'll leave the record open. But please stay in touch with us, and Margaret, I'd be interested in the immunization—that would be really helpful, and I'd be interested in your thoughts on that.

Ms. WILLIAMS. Yes, I'd be glad to do that.

Senator DODD. Thank you.

The subcommittee will stand adjourned until further call of the chair.

[Additional material follows:]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF THE NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE

LATEST CHILD ABUSE AND NEGLECT STATISTICS

Since 1982, the National Committee for Prevention of Child Abuse (NCPCA) has conducted an annual national telephone survey of child protective service (CPS) agencies in all 50 States. The initial surveys focused exclusively on increases in the number of reports and the effects of budget cutbacks. Beginning in 1986, NCPCA developed a more standardized instrument which focused on the number and characteristics of child abuse reports, the number of child abuse fatalities and changes in the funding and scope of child welfare services. This instrument, which has been utilized for the past seven years, provides more reliable estimates of the number of reports and fatalities across time and across States.

It is a pleasure to have the opportunity to describe the 1992 figures at this hearing. A full report on the findings is submitted with my testimony.

The total number of children reported increased once again in 1992, climbing to over 2.9 million children or 45 out of every 1,000 children in the United States. This figure is almost 8 percent higher than the number reported in 1991, and 50 percent higher than the number reported in 1985.

Overall, child abuse reports have maintained a steady growth between 1985 and 1992, with annual increases of about 6 percent. This growth rate, while significant, is significantly less than the annual rate of growth reported in the first half of the decade.

Administrators in states that have experienced increases over the past several years, however, cite several primary factors for this trend. First, economic stress due to poverty, unemployment and related work concerns were cited by 40 percent of the administrators as contributing to increased reports. Second, almost one third of the States said substance abuse accounts for the increase. And third, about 30 percent of these administrators saw the increase as stemming from increased public awareness and willingness to report suspected cases of maltreatment.

Confirmed child abuse fatalities stayed essentially the same over the number reported in 1991. Last year, a total of 1,261 children were officially registered and confirmed as fatal victims of maltreatment. This 1992 statistic is a projected number based on data from 36 States comprising 69 percent of the U.S. child population. We anticipate that this number will increase over the year as States complete their investigations of several hundred suspected cases and all States finalize their 1992 statistics.

Looking across the full eight year reporting period, the rate of child abuse fatalities has increased almost 50 percent. For the past 5 years, essentially three children a day have been killed by their parents or caretakers. Throughout this period, the characteristics of these cases have remained fairly constant. Approximately 40 percent of these deaths occur to children known to the local child welfare system either as prior or current clients. As for the cause of death, 40 percent of the deaths result from physical neglect while 60 percent are the result of physical abuse. Each year the vast majority of these cases have involved young children. In 1992, 84 percent of the victims were under 5 years of age and 43 percent were under one year old.

With respect to funding for CPS, in 1991 only 13 States reported funding increases; five experienced decreases and 30 reported no change in funding levels. According to State administrators states, only 60 percent of the families where abuse was confirmed received any kind of treatment; in other words, 460,000 abused children received no help. Even as reports of child abuse grow, CPS is less and less able to respond effectively, less and less able to further protect children. Relief is desperately needed, especially relief which will help prevent abuse before it occurs. Overall, the system continues to face growing demands with constant or decreasing resources.

THE CASE FOR PREVENTION

Child abuse hurts—the after effects, which are well documented, are devastating. Abused children suffer a wide variety of emotional and developmental as well as physical problems—both acute and chronic. Some children die. These problems often become evident in the emergence of other social ills such as teenage runaways, teen prostitution, alcohol and drug abuse, school problems, and juvenile delinquency. For these reasons, child abuse costs us dearly—from a humane perspective in the injury of a child and from a financial perspective in the ongoing costs associated with responding to the problems which emanate from child abuse.

The case for working to prevent child abuse before it occurs is clear. Prevention spares the hurt and can save lives; prevention also saves money. For those concerned about when intervention can make the biggest difference the results of numerous program evaluations are instructive; prevention approaches have consistently been found to be more likely to produce positive and lasting changes in families than interventions which begin after patterns of abuse or neglect are established (Cohn and Daro, 1988). And, for those concerned about just how overwhelmed the treatment system currently is, the work of prevention may be the best way to reduce this burden. Until we reduce the growing number of maltreatment victims, effective and meaningful child welfare reform will remain elusive.

HOW TO PREVENT CHILD ABUSE

Child abuse is a complex problem with many underlying causes having to do with both individual (e.g., a parent's lack of understanding of child development) and environmental (e.g. poverty) factors. To be successful, prevention efforts must ultimately take account of this diverse etiology. Such a comprehensive approach certainly would include public awareness efforts both to educate the public about the magnitude of the child abuse problem and how to get involved in its prevention and to educate parents on the complexities and stresses associated with rearing a child. Second, certain key prevention services should be put in a place to help all new parents to get off to a good start and to make sure that all parents under stress have access to various crisis and support services, all victims get the therapeutic assistance they need to break the cycle of abuse and all children learn how to utilize existing services and the adults in their lives to protect themselves from abuse. Third, efforts must be directed at certain societal barriers to abuse such as the use of corporal punishment in schools or the amount of media violence, values which may provide parents and adults with excuses for lashing out at children. Finally, issues such as substance abuse, poverty, family and community violence, and cultural diversity must all be addressed if we are to create an environment which reflects our concern for the well-being of our children. The consensus in the field is clear—no single approach, no single program will be enough to prevent abuse; all elements of a comprehensive approach ultimately need to be in place (Cohn, 1983).

WHERE SHOULD PREVENTION EFFORTS BEGIN

While a comprehensive approach to prevention involves a large number of efforts, it makes sense to start with just a few. In 1991, after a year of study of how the United States should respond to the national child abuse emergency, the U.S. Advisory Board on Child Abuse and Neglect declared that while there are dozens of important things to do, a logical place to start is with new parents, helping them get off to a good start before abuse patterns begin (U.S. Advisory Board, 1991). With new parents, especially first time parents, we have the opportunity to encourage and, if necessary, to teach good parenting practices before bad patterns are established. Such a strategy is promising for several reasons. First, new parents are often characterized as "sponges", anxious and ready to learn anything they can about their new babies and how to care for them. Second, most reported cases of physical abuse and neglect occurs among the youngest children (e.g. under age 5) (AAPC, 1988) and, as I reported earlier, young children are by for the most frequent total victims of maltreatment. By focusing on new parents we are reaching the target population where the incidence of physical abuse and neglect is likely to be the greatest. This strategy may not impact all forms of maltreatment. Our knowledge about the effects of working with new parents and the prevention of sexual abuse is scant (Musiak, Bernstein, Percansky, and Stott, 1987); working with new parents may not be among the most important first steps in prevention with sexual abuse as it is with physical abuse and neglect.

WHAT APPROACH TO NEW PARENTS SHOULD WE TAKE

While there are many impressive family support and early intervention models, the U.S. Advisory Board on Child Abuse and Neglect recommends a voluntary program of home visits to new parents and their babies as the desired approach. Many others have expressed similar views. There are a number of reasons why this is so.

Home visiting has widespread appeal. It affords an opportunity to work with individuals in the family context or environment, enabling the professional or volunteer visitor to learn first hand the conditions of life for the parent and child and to respond to them. In other words, it provides the opportunity to tailor the services to be offered to the needs and characteristics of the parent and the child in their own natural setting.

Home visits uniquely offer a way to reach isolated families, families that typically do not participate, in voluntary, prevention services. Such families are often too distrustful or too disorganized to make their way to a center based program or to a workers office. In this sense, home visiting provides a unique opportunity to engage dysfunctional families, who are often the families most at risk of abuse.

The public is very supportive of the home visitor concept. Repeated public opinion polls conducted over the past few years by the National Committee for Prevention of Child Abuse showed that over four-fifths of the respondents thought it appropriate to offer home visits and other supportive services to all first time parents, including families like themselves. While some have argued that the strategy is potentially intrusive and violates a family's right to privacy, it appears the general public does not agree with this characterization.

An additional indicator of just how widespread the appeal is of home visitor services, is the number of such programs which already exist. The National Parent Aide Association, for example, has documented over 650 community-based programs across the country which provide home visitor-type services to parents (Bryant, 1991). Parents As Teachers, a home visiting program working with young parents to help them better prepare their children for school, has over 1,000 service sites in 40 different states across the country. Similarly, the Home Instruction Program for Preschool Youngsters (HIPPY), an early childhood education program for 4 and 5 year olds which involves biweekly home visits by a trained paraprofessional, served over 10,000 families in 17 States last year. Further, national surveys of hospital administrators conducted by NCPCA find that over one-quarter of all hospitals report offering some kind of home visiting services to high-risk new mothers (Daro, 1991).

In addition to the widespread appeal of home visitor services, there is a solid and expanding evaluative data base on the efficacy of the approach. The studies date back over two decades (Daro, 1988). For example, in the early 1970's, the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse conducted a controlled experimental design study of nurse practitioner home visitors with a sample of high risk new parents. The study documented enhanced mother/infant relationships and a reduction in child abuse among the experimental group (Grey, Cutler, Dean and Kempe, 1979).

From the mid 1970's through the early 80's a number of large scale evaluation studies of federally funded child abuse service programs, which included high risk as well as abusive clients, were conducted (Cohn, 1979; Cohn and Daro, 1988; Daro, 1988). The studies compared the relative effectiveness and cost effectiveness of different service interventions. The home visiting services of parent aides, coupled with group services such as group therapy or Parents Anonymous, and homemaker services significantly reduced child abuse potential in contrast to those clients receiving basic counseling or only out-of-home assistance.

Dr. David Olds and his colleagues (1986, 1990) have conducted the longest and perhaps most thoroughly designed and carefully controlled studies of the home visitor model from the scientific perspective. In his first study 400 first time mothers were randomly assigned to four groups of which the most intensive service condition included: (a) intensive pre and post natal visits by a nurse practitioner; (b) parent education on fetal and infant development; (c) involvement of the mothers friends and family in child care and support of the mother and (d) linkages to health and human services. The women viewed as being at greatest risk for child abuse (i.e., low income, unmarried teenagers who received the most intensive service package showed 4 percent abuse at the end of the study in contrast to 19 percent of the highest risk group assigned to the control group; this experimental group also demonstrated fewer accidents, less required use of the emergency room, less need to punish and discipline their children and longer spacing between children. Dr. Olds is cautious in generalizing his findings to all populations noting that the model was found successful only with the young, low income single mothers served.

Other less controlled studies, however, support the value of home visitor services in various settings. Lutzker and Rice (1984, 1987) conducted a study of Project 12 Ways, a multifaceted home-based service program in Southern Illinois in which home visits to new parents were offered by graduate students. At the end of the program abused had been detected in 2 percent of those receiving the home visits in contrast to 11 percent in the control groups. The relative effectiveness of the program continued for at least 1 year. In a one year follow-up, abuse was found in 10 percent of the experimental group and 21 percent of the control group.

Seitz and her colleagues (1985) studied the impact of intensive home visits to first time mothers for 20 months after birth. Follow ups were conducted on 15 of 17 matched sets of families up to 10 years after the program concluded. Seitz documented steady improvements in parenting and family life over the 10-year period,

and, in blind assessments, teachers consistently rated the children enrolled in the program as performing better in school.

Hawaii has conducted several studies of its universal voluntary Healthy Start program in which paraprofessionals intensively visit new parents identified at risk of abuse for up to 5 years after birth. The program includes the provision of other health and child development services as well. In one study, for example, among the over 1,000 high risk parents served, and studied, abuse was reported for less than 1 percent (Breakey and Pratt, 1991).

In summary, these and related studies done on home visitor services consistently suggest that this service approach has significant benefits in the prevention of child abuse and other related problems. These studies are not perfect. Many questions still remain unanswered with respect to home visitor services and should indeed be addressed. And yet, the evidence is convincing enough for the U.S. Advisory Board, the National Committee for Prevention of Child Abuse and others to pursue the delivery of home visitor services for all new parents.

WHAT DO WE KNOW ABOUT WHAT HOME VISITOR PROGRAMS SHOULD LOOK LIKE?

The provision of in-home educational and support services to new parents, such as is done in the state of Hawaii, has been found to be an effective approach to enhancing family functioning. To be successful, however, such services must adopt the best practice standards suggested by repeated evaluations of various early interventions with new parents. While there should be flexibility in service implementation to permit integration into a wide range of communities, as well as opportunity for innovation, there are some basic criteria which contribute to program effectiveness. It is these criteria which must be central to any Healthy Families America (HFA) initiative.

—Initiate services prenatally or at birth.
—Universal intake service for all new parents initially from a defined geographic target area (prenatally or at birth) (e.g., educational hospital visit to all births in a given census tract, zip code.)
—Universal needs assessment using standardized protocol to systematically identify those new parents most in need of services due to the presence of various factors associated with increased risk for child maltreatment and other poor childhood outcomes.
—All high risk parents offered services in a positive, voluntary way.
—Home visitation is the core service offered.
—Creative outreach (e.g., persistent, positive outreach for at least 3 months) to build client trust in accepting services.
—Services offered intensely (e.g., at least once a week.)
—Services offered over the long term (e.g., 3–5 years.)
—Services are family centered addressing the needs of the child within the context of the family and recognizing that the adults in the family are the primary decision makers.
—Services focus both on supporting the parent as well as on supporting parent-child interaction and child development.
—Services include a focus on child health and linkages to a health care system (e.g., assurance of immunizations, visits to well baby clinics.)
—Services include a focus on school readiness directly or by offering linkages to other school readiness services (e.g., Head Start, HIPPY, Parents as Teachers.)
—Service plans tailored to needs of individual family; problem solving to address service needs is foremost; longer term focus of services is on self-sufficiency and empowerment.
—Early identification and home visitation workers selected because of personal characteristics (e.g., non-judgmental, compassionate, ability to establish a trusting relationship, etc.)
—All workers complete intensive, standardized initial training program and periodic in-service training (e.g., every 3 months.)
—All workers receive ongoing, intense professional supervision to assure service quality (e.g., 2 hours of supervision weekly for home visitors; 5–6 home visitors for 1 supervisor.)
—Worker caseloads are limited (e.g., 15 families in project year one; average of 20 families in year two; average of 25 families in year three.)
—Overall focus on service delivery site is on integration with other services in the area (e.g., a single agency may offer the home visitor services but the overall effort is a collaborative one which builds on existing resources in the area.)

In addition to the basic services criteria outlined for all Healthy Families America sites, a number of management criteria have been identified as integral to service effectiveness and continuity, though not necessarily documented by research. These include:

—The creation of a Healthy Families Steering Committee or Advisory Board which will have a long term commitment to assuring the quality of the effort.
—The development of an on-going evaluation program which includes measurable outcomes (e.g., immunization rates, age appropriate development, and reports of child abuse and neglect.)
—The flexibility to allow the service to evolve over time as evaluations indicate that the needs of the target population and the community have changed.
—The maintenance of a cohesive and supportive management style that allows staff to build relationships with each other, with their clients and with the broader community.
—The establishment of regular staff evaluations with clear guidelines for optimal performance.

THE HAWAIIAN APPROACH

A service model embracing these dimensions which reaches all first time parents with intensive home visitor services already exists in the State of Hawaii. There, over the past seven years, the State's Maternal and Child Health Program has pilot tested, evaluated and now put into place for over 50 percent of their new parents a program called "Healthy Start." Visits by paraprofessionals to all new parents identified as being in potential need of assistance begin in the hospital at the time of birth and for those parents in the most difficult circumstances continue during the critical first months and if necessary, first years of the child's life. As noted earlier, the services thus far have resulted in the virtual elimination of physical child abuse in the population served. The visits are voluntary; very few of the at risk parents refuse the services. The home visits are complemented by an impressive array of medical, child development and social services. The home visitors receive intensive training and ongoing supervision. The program is a public/private sector partnership with the State administering the program and private agencies delivering the services. The State's goal is to serve 100 percent of new parents within the next several years.

A NATIONAL INTEREST IN HAWAII'S PROGRAM BUT NO FUNDS TO FOLLOW THROUGH

Because of the U.S. Advisory Board's recommendation, because of the general interest in the field in helping new parents get off to a good start, and the growing data base showing the effectiveness of the home visitor approach, last year the National Committee for Prevention of Child Abuse, in partnership with the Ronald McDonald Children's Charities (RMCC), launched a national initiative entitled "Healthy Families America". The initiative seeks to make sure that all new parents, especially those at high risk, get off to a good start by replicating the Hawaii model across the country. We are working in conjunction with the Hawaii Family Stress Center and Hawaii's Maternal and Child Health Departments and other interested State and national organizations. To date, initial efforts have begun in 46 States and pilot programs are now operating at 22 sites.

THE FAMILY PRESERVATION AND SUPPORT ACT: A CRITICAL CATALYST FOR CHANGE

Child abuse reports and, most tragically, documented child abuse fatalities have risen once again in the last year. The child abuse problem remains a national emergency. As a nation we spend in excess of $2 billion responding to the problem after it has occurred. We spend over $2 billion investigating whether or not abuse has occurred and offering inadequate, often ineffective services to families already crushed by abuse. It is time for change. Even as we invest more in effectively supporting families where abuse has already happened, is time for a major investment in the prevention of child abuse before it occurs. For two decades we have been accumulating evidence on the desirability of various family support programs including offering new parents intensive home visitor services to prevent child abuse. The evidence now in tells us that this is an effective and indeed cost effective approach. It is time for the nation to invest in family support efforts including program of neonatal home visitation for new parents in the most difficult circumstances. The proposed Family Preservation and Support Act would begin to offer States some relief for the crisis they face in responding to families where abuse has already happened while also making available important funds for needed prevention interventions.

Our goal is to lay the foundation for a nation-wide, voluntary neo-natal home visiting program with a network of state level organizations that are willing to establish intensive home visitor services. Initially we contacted state Health and Social Service Departments, the State Children's Trust Funds, our State chapters, and other key groups and invited them to join our Healthy Families America initiative. We offered training and technical assistance in exchange for a commitment on their part to work in teams of public and private at the state level to test the replication of the Hawaiian approach. Since January, 1992 forty-six (46) States have signed on to putting into place universal, intensive long term home visiting services for new parents, especially those at risk of abuse. And, in 22 communities pilot efforts have begun.

What we have found through our training and technical assistance efforts to interested States is that the biggest barrier to replicating the Hawaiian approach is a lack of resources. State child protective service departments in particular do not have a preventive program. And yet, these are the very kinds of programs which in time would help reduce the overall number of child abuse cases and thus the burden these departments now face. It is time that we begin the task of serious child welfare reform, reform that will not only result in a more effective service delivery system but will also protect children from needless abuse and neglect.

REFERENCES

American Association for Protecting Children. (1988). Highlights of Official Child Neglect and Abuse Reporting. 1986. Denver, CO.: American Human Association.

Austin, M.J. (1978). Professionals and Paraprofessionals. New York: Human Science Press.

Breakey, G. and Pratt, B. (1991). "Healthy Growth for Hawaii's 'Healthy Start': Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect." Zero to Three. 11(4).

Bryant G. (1991). Presentation, National Conference on Child Abuse and Neglect, Denver, September.

Carkhuff, R. (1968). "Differential functioning of lay and professional helpers." Journal of Counseling Psychology. 15:2, pp. 117–126.

Cohn, A. (1979). "Effective treatment of child abuse and neglect." Social Work. 24:6 (November), pp. 513–519.

Cohn, A. (1983). An Approach to Preventing Child Abuse. Chicago, IL.: National Committee for Prevention of Child Abuse.

Cohn, A. and Daro, D. (1988). "Is treatment too late: what ten years of evaluative research tell us." Child Abuse and Neglect. 11(3), pp. 433–442.

Cohn, A. and DeGraff, B. (1982). "Assessing Case Management in the Child Abuse Field." Journal of Social Service Research. 5 (1–2).

Daro, D. (1988). Confronting Child Abuse. New York: Free Press.

Daro, D. (1991). Child Abuse Prevention Efforts: Final Report on NCPCA's Progress Toward Its Goal To Reduce Child Abuse 20 percent by 1990. Chicago, IL.: National Committee for Prevention of Child Abuse.

Daro, D. (1992). Public Attitudes and Behaviors with Respect to Child Abuse Prevention: 1987–1991. Chicago, IL.: National Committee for Prevention of Child Abuse.

Daro, D. and McCurdy, K. (1993). Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1992 Annual 50-State Survey. Chicago: National Committee for Prevention of Child Abuse.

Daro, D., Jones, E., and McCurdy, K. (1992). The William Penn Foundation Prevention Initiative: Final Evaluation Report. Chicago, IL: National Committee for Prevention of Child Abuse.

Gray, J., Cutler, C.A., Dean, J.G. and Kempe, C.H. (1979). "Prediction and prevention of child abuse and neglect." Journal of Social Issues. 35 (2), pp. 127–139.

Halpren, R. and Larner, M. (1987). "Lay family support during pregnancy and infancy: the Child Survival/Fair Start Initiative." Infant Mental Health Journal. 8:2, 130–143.

Larner, M. (1990). "A 'Fair Start' for parents and infants." High Scope Review. 9:1 (Winter), 5–6, 8–10.

Larson, C. (1980). "Efficacy of prenatal and postpartum home visits on child health and development." Pediatrics. 66, 191–197.

Lutzker, J. and Rice, J. (1984). "Project 12-Ways: Measuring Outcome of a large in-home service for treatment and prevention of child abuse and neglect." Child Abuse and Neglect. 8, 519–524.

Lutzker, J. and Rice, J. (1987). "Using recidivism data to evaluate Project 12-Ways: an ecobehavioral approach to the treatment and prevention of child abuse and neglect." Journal of Family Violence, 2:4, 283–290.

Musiak, J., Bernstein, B., Percansky, C., and Stott, F. (1987). "A chain of enablement: using community-based programs to strengthen relationships between teen parents and their infants." Zero to Three. 8:2 (December), 1–6.

Olds, D. and Henderson, C., Jr. (1990). "The prevention of maltreatment." in Cicchetti, D. and Carlson, V. (Eds.). Child Maltreatment. New York: Cambridge University Press, 722–763.

Olds, D., Chamberlin, R. and Tatlebaum, R. (1986). "Preventing child abuse and neglect: a randomized trial of nurse home visitation." Pediatrics. 78, 65–78.

Olds, D. and Kitzman, H. (1990). "Can Home Visitation Improve the Health of Women and Children at Environmental Risk." Pediatrics. (86), No.1, pp. 108–116.

Seitz, V., Rosenbaum, L. and Apfel, N. (1985). "Effects of family support intervention: a ten-year follow-up." Child Development. 56, 376–391.

U. S. Advisory Board on Child Abuse and Neglect. (1991). Creating Caring Communities: Blueprint For An Effective Federal Policy on Child Abuse and Neglect. Washington, DC.: U.S. Department of Health and Human Services.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

○

ISBN 0-16-041404-0